(for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2900. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2901. Mr. THUNE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2902. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2903. Ms. SNOWE (for herself, Mr. DURBIN, Mr. MERKLEY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2904. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2905. Mrs. LINCOLN (for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2906. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2907. Ms. KLOBUCHAR (for herself, Mr. THUNE, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2908. Ms. KLOBUCHAR (for herself and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2909. Mr. NELSON, of Florida (for himself, Mr. REID, Mr. SCHUMER, Mr. KERRY, Ms. STABENOW, and Mr. LEAHY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2910. Mr. FRANKEN (for himself, Mr. ROCKEFELLER, Mrs. LINCOLN, Mr. WHITEHOUSE, Mr. LEAHY, Mr. SANDERS, Mr. BROWN, and Mr. BEGICH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H .R. 3590, supra; which was ordered to lie on the table.

SA 2911. Mr. FRANKEN (for himself and Mr. LUGAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2912. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2913. Mr. WHITEHOUSE (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2914. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2915. Mrs. SHAHEEN (for herself, Mr. BROWN, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2916. Mr. UDALL of New Mexico (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2917. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2918. Mr. MENENDEZ (for himself, Ms. STABENOW, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2919. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2920. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2921. Ms. STABENOW (for herself and Mrs. MCCASKILL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2922. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2923. Mr. DORGAN (for himself, Mr. WHITEHOUSE, Mr. UDALL of New Mexico, Mr. BEGICH, Mr. JOHNSON, Mr. FRANKEN, Ms. CANTWELL, Mr. UDALL of Colorado, Mr. TESTER, and Mr. INOUYE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2880. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

TITLE X—DELAYED IMPLEMENTATION

SEC. 10001. DELAYED IMPLEMENTATION.

Notwithstanding any other provision of this Act, or the amendments made by this Act, such provisions or amendments shall not take effect before the date that the Board of Trustees of the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) submits an annual report to Congress under subsection (b)(2) of such section that includes a statement that such Trust Fund is projected to be solvent through 2037.

SA 2881. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, strike lines 1 through 20.

SA 2882. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. PROTECTING MEDICARE BENEFICIARIES' ACCESS TO HOME HEALTH SERVICES.

Notwithstanding the provisions of, and amendments made by, sections 3131 and 3401(e), such provisions and amendments are repealed.

SA 2883. Ms. STABENOW (for herself, Mr. KERRY, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

In subtitle C of title IV, insert the following at the end:

SEC. 4208. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) SHORT TITLE.—This section may be cited as the ''Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009'' or the ''ENHANCED Act of 2009''.

(b) CENTERS OF EXCELLENCE FOR DEPRESSION.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et

seq.) is amended by inserting after section 520A the following:

"SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

''(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term 'depressive disorder' means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

''(b) GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as 'centers of excellence'), which shall engage in activities related to the treatment of depressive disorders.

''(2) ALLOCATION OF AWARDS.—If the funds authorized under subsection (f) are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

''(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 centers of excellence may be established; and

''(B) not later than September 30, 2016, not more than 30 centers of excellence may be established.

''(3) GRANT PERIOD.—

''(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

''(B) RENEWAL.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

''(4) USE OF FUNDS.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

''(5) ELIGIBLE ENTITIES.—

''(A) REQUIREMENTS.—To be eligible to receive a grant under this section, an entity shall—

''(i) be an institution of higher education or a public or private nonprofit research institution; and

''(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

''(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

''(i) evidence that such entity—

''(I) provides, or is capable of coordinating with other entities to provide, comprehensive medical services with a focus on mental health services and subspecialty expertise for depressive disorders;

''(II) collaborates with—

''(aa) other medical subspecialists to address co-occurring mental illnesses;

''(bb) community organizations; and

''(cc) other members of the network;

''(III) is capable of training health professionals about mental health; and

''(ii) such other information, as the Secretary may require.

''(C) PRIORITIES.—In awarding grants under this section, the Secretary shall give priority to eligible entities that meet 1 or more of the following criteria:

''(i) Demonstrated capacity and expertise to serve the targeted population.

''(ii) Existing infrastructure or expertise to provide appropriate, evidence-based and culturally competent services.

''(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

''(iv) A history of serving the population described in clause (iii).

''(v) Proposed innovative approaches for outreach to initiate or expand services.

''(vi) Use of the most up-to-date science, practices, and interventions available.

''(vii) Demonstrated coordination and collaboration, or having a viable plan to coordinate, with a community mental health center or other community mental health resources.

''(viii) Capacity to establish cooperative agreements with other community entities to provide social and human services to individuals with depressive disorders.

''(ix) Demonstrated potential for replication and dissemination of evidence-based research and practices.

''(6) SPECIALTY CENTERS.—Of the centers of excellence receiving a grant under this section, the Secretary may select 1 or more such centers to specialize in—

''(A) subspecialties such as prepartum and postpartum depression, traumatic stress disorder, suicidal tendency, bipolar disorder, and depression; and

''(B) providing mental health services to communities with problems of access, such as rural communities and economically depressed communities.

''(7) NATIONAL COORDINATING CENTER.—

''(A) IN GENERAL.—The Secretary, acting through the Administrator, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the 'coordinating center'). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in subparagraph (C).

''(B) APPLICATION.—A center of excellence that has been awarded a grant under paragraph (1) may apply for designation as the coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(C) DUTIES.—The coordinating center shall—

''(i) develop, administer, and coordinate the network of centers of excellence under this section;

''(ii) oversee and coordinate the national database described in subsection (d);

''(iii) lead a strategy to disseminate the findings and activities of the centers of excellence through such database;

''(iv) serve as a liaison with the Administration, the National Registry of Evidence-based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health; and

''(v) establish a common network infrastructure to advance services provided by the centers of excellence and demonstrate effectiveness in fostering a collaborative community among such centers for sharing knowledge and skills.

''(8) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(c) ACTIVITIES OF THE CENTERS OF EXCELLENCE.—Each center of excellence shall carry out the following activities:

''(1) GENERAL ACTIVITIES.—Each center of excellence shall—

''(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development of evidence-based interventions;

''(B) involve a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop the research agenda and disseminate the research findings of such center, and to provide support in the implementation of evidence-based practices;

''(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders;

''(D) facilitate the dissemination and communication of research findings and depressive disorder-related information from the institutions of higher education to the public; and

''(E) educate policy makers, employers, community leaders, and the general public about depressive disorders to reduce stigma and raise awareness of available treatments for such disorders.

''(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, AND DIAGNOSTIC PROTOCOLS.—Each center of excellence shall collaborate with other centers of excellence in the network to—

''(A) develop and implement treatment standards, clinical guidelines, and protocols to improve the accuracy and timeliness of diagnosis of depressive disorders; and

''(B) develop and implement treatment standards that emphasize early intervention and treatment for, primary prevention and the prevention of recurrences of, and recovery from, depressive disorders.

''(3) COORDINATION AND INTEGRATION OF PHYSICAL, MENTAL, AND SOCIAL CARE.—Each center of excellence shall—

''(A) incorporate principles of chronic care coordination and integration of services that address physical, mental, and social conditions in the treatment of depressive disorders;

''(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

''(C) identify how treatment for depression interacts with such co-occurring illnesses to improve overall health outcomes;

''(D) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans; and

''(E) use electronic health records and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

''(4) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS OF EXCELLENCE AND COMMUNITY-BASED ORGANIZATIONS.—Each center of excellence shall—

''(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

''(B) expand multidisciplinary, translational, and patient-oriented research and treatment by fostering such collaborations; and

''(C) coordinate with accredited academic programs to provide ongoing opportunities, in academic and in community settings, for the professional and continuing education of mental health providers.

''(d) NATIONAL DATABASE.—

''(1) IN GENERAL.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the centers of excellence, as described in paragraph (2).

''(2) DATA COLLECTION.—

''(A) DATA.—Each center of excellence shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

''(i) the prevalence and incidence of depressive disorders;

''(ii) the health and social outcomes of individuals with depressive disorders;

''(iii) the effectiveness of interventions designed, tested, and evaluated;

''(iv) the progress in the prevention of, and recovery from, depressive disorders; and

''(v) the economic impact of the activities of such center.

''(B) FINANCIAL INFORMATION.—Each center of excellence shall provide to the coordinating center appropriately summarized financial information to enable the coordinating center to assess the efficiency and financial sustainability of such center.

''(3) SUBMISSION OF DATA TO THE ADMINISTRATOR.—The coordinating center shall submit to the Administrator the data and financial information gathered under paragraph (2).

''(4) PUBLICATION USING DATA FROM THE DATABASE.—A center of excellence, or an individual affiliated with a center of excellence, may publish findings using the data described in paragraph (2)(A) only if such center submits such data to the coordinating center, as required under such paragraph.

''(e) ESTABLISHMENT OF STANDARDS; REPORT CARDS AND RECOMMENDATIONS; THIRD PARTY REVIEW.—

''(1) ESTABLISHMENT OF STANDARDS.—The Secretary, acting through the Administrator, shall establish performance standards for—

''(A) each center of excellence; and

''(B) the network of centers of excellence as a whole.

''(2) REPORT CARDS.—The Secretary, acting through the Administrator, shall—

''(A) for each center of excellence, not later than 3 years after the date on which such center of excellence is established and annually thereafter, issue a report card to the coordinating center to rate the performance of such center of excellence; and

''(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

''(3) RECOMMENDATIONS.—Based upon the report cards described in paragraph (1), the Secretary shall, not later than September 30, 2015—

''(A) make recommendations to the centers of excellence regarding improvements such centers shall make; and

''(B) make recommendations to Congress for expanding the centers of excellence to serve individuals with other types of mental disorders.

''(4) THIRD PARTY REVIEW.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of centers of excellence to ensure that such centers are meeting the goals of this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated—

''(A) $100,000,000 for each of the fiscal years 2011 through 2015; and

''(B) $150,000,000 for each of the fiscal years 2016 through 2020.

''(2) ALLOCATION OF FUNDS AUTHORIZED.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each center of excellence receiving a grant under this section, but in no case may the allocation be more than $5,000,000, except that the Secretary may allocate not more than $10,000,000 to the coordinating center.''.

(c) SENSE OF THE SENATE.—It is the sense of the Senate that the knowledge and research developed by the centers of excellence for depression established under section 520B of the Public Health Service Act should be disseminated broadly within the medical community and the Federal Government, particularly to agencies with an interest in mental health, including other agencies within the Department of Health and Human Services and the Departments of Justice, Defense, Labor, and Veterans Affairs.

SA 2884. Ms. STABENOW (for herself, Mr. KERRY, Mrs. BOXER, Ms. KLOBUCHAR, Mr. BAYH, Mr. LAUTENBERG, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VII, insert the following:

Subtitle C—Heart Disease Education, Analysis Research, and Treatment for Women

SEC. 7201. SHORT TITLE.

This subtitle may be cited as the ''Heart Disease Education, Analysis Research, and Treatment for Women Act'' or the ''HEART for Women Act''.

SEC. 7202. REPORTING OF DATA IN APPLICATIONS FOR DRUGS, BIOLOGICAL PRODUCTS, AND DEVICES.

(a) DRUGS.—

(1) NEW DRUG APPLICATIONS.—Section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) is amended—

(A) in paragraph (1), in the second sentence—

(i) by striking ''drug, and (G)'' and inserting ''drug; (G)''; and

(ii) by inserting before the period the following: ''; and (H) the information required under paragraph (7)''; and

(B) by adding at the end the following:

''(7)(A) With respect to clinical data in an application under this subsection, the Secretary may deny such an application if the application fails to meet the requirements of sections 314.50(d)(5)(v) and 314.50(d)(5)(vi)(a) of title 21, Code of Federal Regulations.

''(B) The Secretary shall modify the sections referred to in subparagraph (A) to require that an application under this subsection include any clinical data possessed by the applicant that relates to the safety or effectiveness of the drug involved by gender, age, and racial subgroup.

''(C) Promptly after approving an application under this subsection, the Secretary shall, through an Internet Web site of the Department of Health and Human Services, make available to the public the information submitted to the Secretary pursuant to subparagraphs (A) and (B), subject to sections 301(j) and 520(h)(1) of this Act, subsection (b)(4) of section 552 of title 5, United States Code (commonly referred to as the 'Freedom of Information Act'), and other provisions of law that relate to trade secrets or confidential commercial information.

''(D) The Secretary shall develop guidance for staff of the Food and Drug Administration to ensure that applications under this subsection are adequately reviewed to determine whether the applications include the information required pursuant to subparagraphs (A) and (B).''.

(2) INVESTIGATIONAL NEW DRUG APPLICATIONS.—Section 505(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i)) is amended—

(A) in paragraph (2), by striking ''Subject to paragraph (3),'' and inserting ''Subject to paragraphs (3) and (5),'' ; and

(B) by adding at the end the following:

''(5)(A) The Secretary may place a clinical hold (as described in paragraph (3)) on an investigation if the sponsor of the investigation fails to meet the requirements of section 312.33(a) of title 21, Code of Federal Regulations.

''(B) The Secretary shall modify the section referred to in subparagraph (A) to require that reports under such section include any clinical data possessed by the sponsor of the investigation that relates to the safety or effectiveness of the drug involved by gender, age, and racial subgroup.''.

(b) BIOLOGICAL PRODUCT LICENSE APPLICATIONS.—Section 351 of the Public Health Service Act (42 U.S.C. 262), as amended by section 7002, is further amended by adding at the end the following:

''(n) The provisions of section 505(b)(7) of the Federal Food, Drug, and Cosmetic Act (relating to clinical data submission) apply with respect to an application under subsection (a) of this section to the same extent and in the same manner as such provisions apply with respect to an application under section 505(b) of such Act.''.

(c) DEVICES.—

(1) PREMARKET APPROVAL.—Section 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360e) is amended—

(A) in subsection (c)(1)—

(i) in subparagraph (G)—

(I) by moving the margin 2 ems to the left; and

(II) by striking ''and'' after the semicolon at the end;

(ii) by redesignating subparagraph (H) as subparagraph (I); and

(iii) by inserting after subparagraph (G) the following subparagraph:

''(H) the information required under subsection (d)(7); and''; and

(B) in subsection (d), by adding at the end the following paragraph:

''(7) To the extent consistent with the regulation of devices, the provisions of section 505(b)(7) (relating to clinical data submission) apply with respect to an application for premarket approval of a device under subsection (c) of this section to the same extent and in the same manner as such provisions apply with respect to an application for premarket approval of a drug under section 505(b).''.

(2) INVESTIGATIONAL DEVICES.—Section 520(g)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j(g)(2)) is amended by adding at the end the following subparagraph:

''(D) To the extent consistent with the regulation of devices, the provisions of section 505(i)(5) (relating to individual study information) apply with respect to an application for an exemption pursuant to subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to an application for an exemption under section 505(i).''.

(d) RULES OF CONSTRUCTION.—This subtitle and the amendments made by this subtitle may not be construed—

(1) as establishing new requirements under the Federal Food, Drug, and Cosmetic Act relating to the design of clinical investigations that were not otherwise in effect on the day before the date of the enactment of this Act; or

(2) as having any effect on the authority of the Secretary of Health and Human Services to enforce regulations under the Federal Food, Drug, and Cosmetic Act that are not expressly referenced in this subtitle or the amendments made by this subtitle.

(e) APPLICATION.—This section and the amendments made by this section apply only with respect to applications received under section 505 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) on or after the date of the enactment of this Act.

SEC. 7203. REPORTING AND ANALYSIS OF PATIENT SAFETY DATA.

(a) DATA STANDARDS.—Section 923(b) of the Public Health Service Act (42 U.S.C. 299b–23(b)) is amended by adding at the end the following: ''The Secretary shall provide that all nonidentifiable patient safety work product reported to and among the network of patient safety databases be stratified by sex.''.

(b) USE OF INFORMATION.—Section 923(c) of the Public Health Service Act (42 U.S.C. 299b–23(c)) is amended by adding at the end the following: ''Such analyses take into account data that specifically relates to women and any disparities between treatment and the quality of care between males and females.''.

SEC. 7204. QUALITY OF CARE REPORTS BY THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

Section 903 of the Public Health Service Act (42 U.S.C. 299a–1) is amended—

(1) in subsection (b)(1)(B), by inserting before the semicolon the following: '', and including quality of and access to care for women with heart disease, stroke, and other cardiovascular diseases''; and

(2) in subsection (c), by adding at the end the following:

''(4) ANNUAL REPORT ON WOMEN AND HEART DISEASE.—Not later than September 30, 2011, and annually thereafter, the Secretary, acting through the Director, shall prepare and submit to Congress a report concerning the findings related to the quality of and access to care for women with heart disease, stroke, and other cardiovascular diseases. The report shall contain recommendations for eliminating disparities in, and improving the treatment of, heart disease, stroke, and other cardiovascular diseases in women.''.

SEC. 7205. EXTENSION OF WISEWOMAN PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that follows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $70,000,000 for fiscal year 2010, $73,500,000 for fiscal year 2011, $77,000,000 for fiscal year 2012, $81,000,000 for fiscal year 2013, and $85,000,000 for fiscal year 2014.''.

SA 2885. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, insert the following:

SEC. 4109. REAUTHORIZATION OF TELEHEALTH PROGRAMS.

(a) TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.—Section 102(b) of the Health Care Safety Net Amendments of 2002 (42 U.S.C. 254c-17(b)) is amended by striking ''2002 through 2006'' and inserting ''2011 through 2015''.

(b) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I(s) of the Public Health Service Act (42 U.S.C. 254c-14(s)) is amended—

(1) in paragraph (1), by striking ''2003 through 2006'' and inserting ''2011 through 2015''; and

(2) in paragraph (2), by striking ''2003 through 2006'' and inserting ''2011 through 2015''.

(c) MENTAL HEALTH SERVICES DELIVERED VIA TELEHEALTH.—Section 330K(g) of the Public Health Service Act (42 U.S.C. 254c–16(g)) is amended by striking ''2003 through 2006'' and inserting ''2011 through 2015''.

SA 2886. Mr. FEINGOLD (for himself, Ms. KLOBUCHAR, Mr. KOHL, and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 751, between lines 2 and 3, insert the following:

SEC. 3022A. IMPROVEMENTS IN THE MEDICARE SHARED SAVINGS PROGRAM.

(a) IN GENERAL.—Section 1899 of the Social Security Act, as added by section 3022, is amended—

(1) in subsection (b)—

(A) in paragraph (1)(D), by inserting ''or critical access hospitals'' before the period at the end; and

(B) in paragraph (2), by adding at the end the following new subparagraph:

''(I) The ACO shall take into account the special needs of hospitals located in rural areas.''; and

(2) by striking subsection (d)(1)(B)(ii) and inserting the following new clause:

''(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO that is based—

''(I) 50 percent on the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO; and

''(II) 50 percent on the national average of the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries.

Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period. In establishing the benchmarks under this clause, the Secretary implements the amendment made by section 3022A(2) in a budget-neutral manner.''.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the applicability of Accountable Care Organizations (ACOs) in rural, frontier areas. Such study shall include an analysis of—

(A) ways to demonstrate that Accountable Care Organizations or similar models might successfully form in rural, frontier areas in order to ensure that under-populated areas are able to benefit from the shared savings and care coordination offered by Accountable Care Organizations; and

(B) other areas determined appropriate by the Secretary.

(2) REPORT.—Not later than January 1, 2011, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SA 2887. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1302 and insert the following:

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

In this title, the term ''essential health benefits'' means, with respect to any health plan, coverage that meets the same statutory requirements for plans offered to Members of Congress (as enumerated in section 8904(a) of title 5, United States Code).

SA 2888. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of section 1323, add the following:

(1) IMPLEMENTATION.—Notwithstanding any other provision of this title (or an amendment made by this title), this section shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services, in consultation with the National Association of Insurance Commissioners, certifies to Congress that the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) meets the standards for risk-based capital as established by the National Association of Insurance Commissioners.

SA 2889. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1979, strike line 20 and all that follows through page 1996, line 3, and insert the following:

SEC. 9001. CAP ON EXCESS MEDICAL INFLATION.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

"SEC. 4980I. EXCESS MEDICAL COSTS OF HEALTH BENEFITS PLANS.

''(a) GENERAL RULE.—In the case of any health benefits plan which has excess health plan costs in any plan year, there is hereby imposed a penalty equal to 40 percent of such excess health plan costs.

''(b) EXCESS HEALTH PLAN COSTS.—For purposes of this section—

''(1) EXCESS HEALTH PLAN COSTS.—The term 'excess health plan costs' means, with respect to any health benefits plan which has an excess medical inflation rate in excess of zero for any year, the product of—

''(A) the applicable premium of such health benefits plan for such year, and

''(B) the excess medical inflation rate for such plan for such year.

''(2) EXCESS MEDICAL INFLATION RATE.—The term 'excess medical inflation rate' means, with respect to any health benefits plan for any year, the amount equal to the excess of—

''(A) the core medical inflation trend rate of such health benefits plan for such year, over

''(B) the medical inflation cap for such year.

''(3) CORE MEDICAL TREND RATE.—The term 'core medical trend rate' means, with respect to any health benefits plan for any year, the amount (expressed as a percentage), if any, by which—

''(A) the actuarially adjusted premium of such plan for such plan for such year, exceeds

''(B) the applicable premium of such plan for the preceding plan year.

''(4) MEDICAL INFLATION CAP.—

''(A) YEARS 2013 TO 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2012 and before 2020, the medical inflation cap shall be the sum of—

''(I) the annualized rate of growth of the gross domestic product for the preceding calendar year (as calculated in the third quarter of the preceding year), plus

''(II) the applicable amount.

''(ii) APPLICABLE AMOUNT.—For purposes of clause (i)(II), the applicable amount shall be determined as follows:

''In the case of a plan year beginning in calendar year—	The applicable amount is—
2013	1.1 percentage points
2014	0.8 percentage points
2015, 2016, 2017, 2018, or 2019.	0.5 percentage points

''(B) YEARS AFTER 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2019, the medical inflation cap shall be equal to the amount (expressed as a percentage), if any, by which—

''(I) the average applicable premium for a low-cost plan for such calendar year, exceeds

''(II) the average applicable premium for a low-cost plan for the preceding calendar year.

''(ii) AVERAGE APPLICABLE PREMIUM FOR A LOW-COST PLAN.—For purposes of this subparagraph, the term 'average applicable premium for a low-cost plan' means the average of the applicable premiums for health benefits plans with applicable premiums below the 33rd percentile, determined by weighting such health benefits plans by the number of individuals enrolled in the plan.

''(c) APPLICABLE PREMIUM; ACTUARIALLY ADJUSTED PREMIUM.—For purposes of this section—

''(1) APPLICABLE PREMIUM.—The term 'applicable premium' has the meaning given such term under section 4980B(f)(4).

''(2) ACTUARIALLY ADJUSTED PREMIUM.—

''(A) IN GENERAL.—The term 'actuarially adjusted premium' means, for any health benefits plan for any year, the applicable premium for such year adjusted, according to actuarial standards and the method prescribed by the Secretary under subparagraph (B), by excluding any cost attributable to—

''(i) the attributes of individuals (such as age, gender, and health risk measures) covered under the plan,

''(ii) the different categories of family structure covered under the plan (such as the policies with self-only coverage, family coverage, or other categories of coverage), and

''(iii) changes in benefits or cost-sharing that result in changes the actuarial value of the plan.

''(B) METHODOLOGY.—The Secretary, in consultation with the Secretary of Health and Human Services, shall issue regulations establishing a standard methodology for adjusting a health benefits plan's applicable premiums under subparagraph (A). In the case of any change described in subparagraph (A)(iii), premiums shall be adjusted so that the calculation of the core medical trend rate is made as a comparison between two actuarially equivalent plans.

''(d) LIABILITY FOR PENALTIES.—

''(1) IN GENERAL.—Each coverage provider shall pay the penalty imposed by subsection (a).

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—In the case of a health benefits plan provided under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) OTHER COVERAGE.—In the case of any other health benefits plan, the person that administers the plan benefits.

''(e) EXEMPTIONS.—

''(1) NEW INSURERS AND NEW EMPLOYERS.—This section shall not apply to any health benefits plan which has provided coverage for less than 12 months.

''(2) FIXED INDEMNITY HEALTH COVERAGE PURCHASED WITH AFTER-TAX DOLLARS.—This section shall not apply to any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

''(3) CERTAIN GOVERNMENT PLANS.—This section shall not apply to the following:

''(A) MEDICARE.—Coverage under part A, part B, part C, or part D of title XVIII of the Social Security Act.

''(B) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(C) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(D) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1705(a) of such title.

''(4) LOW-COST PLANS.—

''(A) IN GENERAL.—This section shall not apply to any health benefits plan for which the actuarial value for the plan year is not more than the applicable threshold.

''(B) APPLICABLE THRESHOLD.—For purposes of this paragraph, the applicable threshold means the dollar amount which is equal to the actuarial value of the health benefits plan which is at the 10th percentile of actuarial value for all health benefits plans.

''(f) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) HEALTH BENEFITS PLAN.—

''(A) IN GENERAL.—The term 'health benefits plan' means health insurance coverage and a group health plan.

''(B) GOVERNMENT PLANS INCLUDED.—Such term shall include a plan established and maintained for its civilian employees by the Government of the United States or the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms by section 9832(b).

''(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term under section 5000(b).

''(4) REGULATIONS FOR HEALTH BENEFITS PLANS WITH DIFFERENT PRODUCT LINES.—The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for the combination of product lines of health benefits plans of any health insurance issuer for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess health plan costs determined separately with respect to each product line.

''(5) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS AMONG EMPLOYERS AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health benefit plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium for the preceding plan year to the coverage of health plan members in their previous group.

''(6) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by this Act, is amended by adding at the end the following new item:

''Sec. 4980I. Excess medical inflation cap.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2012.

SA 2890. Mr. CARPER submitted an amendment intended to be proposed to

amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ADVANCE CARE PLANNING.

(a) DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.—

(1) IN GENERAL.—A qualified health plan (as defined in section 1301(a)) shall—

(A) provide for the dissemination of information related to end-of-life planning to individuals seeking enrollment in qualified health plans offered through an Exchange;

(B) present such individuals with—

(i) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(ii) information related to other planning tools; and

(C) not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under subparagraph (B) shall not presume the withdrawal of treatment and shall include end-of-life planning information that includes options to maintain all or most medical interventions.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(B) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health plan; or

(C) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(3) ADVANCED DIRECTIVE DEFINED.—In this subsection, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care.

(4) PROHIBITION ON THE PROMOTION OF ASSISTED SUICIDE.—

(A) IN GENERAL.—Subject to subparagraph (C), information provided to meet the requirements of paragraph (1)(B) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing, regardless of legality.

(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed to apply to or affect any option to—

(i) withhold or withdraw of medical treatment or medical care;

(ii) withhold or withdraw of nutrition or hydration; and

(iii) provide palliative or hospice care or use an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(C) NO PREEMPTION OF STATE LAW.—Nothing in this subsection shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making.

(b) VOLUNTARY ADVANCE CARE PLANNING CONSULTATION UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 4103, is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (EE);

(ii) by adding ''and'' at the end of subparagraph (FF); and

(iii) by adding at the end the following new subparagraph:

''(GG) voluntary advance care planning consultation (as defined in subsection (iii)(1));''; and

(B) by adding at the end the following new subsection:

''Voluntary Advance Care Planning Consultation

''(iii)(1) Subject to paragraphs (3) and (4), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

''(A) An explanation by the practitioner of advance care planning, including a review of key questions and considerations, advance directives (including living wills and durable powers of attorney) and their uses.

''(B) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(C) An explanation by the practitioner of physician orders regarding life sustaining treatment or similar orders, in States where such orders or similar orders exist.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatments, such as a nurse practitioner or physician assistant).

''(3) An individual may receive the voluntary advance care planning care planning consultation provided for under this subsection no more than once every 5 years unless there is a significant change in the health or health-related condition of the individual.

''(4) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that effectively communicates the individual's preferences regarding life sustaining treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.''.

(2) CONSTRUCTION.—The voluntary advance care planning consultation described in section 1861(iii) of the Social Security Act, as added by paragraph (1), shall be completely optional. Nothing in this subsection shall—

(A) require an individual to complete an advance directive, an order for life sustaining treatment, or other advance care planning document;

(B) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title; or

(C) encourage the promotion of suicide or assisted suicide.

(3) PAYMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 4103, is amended by inserting ''(2)(GG),'' after ''assessment),''.

(4) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)), as amended by section 4103, is amended—

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P) by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(Q) in the case of voluntary advance care planning consultations (as defined in paragraph (1) of section 1861(iii)), which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

SA 2891. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1240, between lines 5 and 6, insert the following:

SEC. 4208. WORKPLACE WELLNESS GRANTS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Beginning in fiscal year 2011, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to eligible small businesses to provide access to comprehensive, evidence-based workplace wellness programs.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a small business shall—

(1) employ less than 100 full or part-time employees; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the wellness program to be carried out using grant funds.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A small business shall use amounts received under a grant under this section to carry out a qualifying wellness program described in paragraph (2).

(2) QUALIFYING WELLNESS PROGRAM.—A qualifying wellness program is described in this paragraph is a program—

(A) under which all employees would be eligible to participate;

(B) that is consistent with evidence-based research and best practices, as determined by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs; and

(C) that includes the following components that have proven to be effective in helping employees make health choices:

(i) Health awareness (such as health education, preventive screenings and health risk assessments).

(ii) Employee engagement (such as mechanisms to encourage employee participation).

(iii) Behavioral change (including elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials).

(iv) Supportive environment (such as creating on-site policies that encourage healthy

lifestyles, healthy eating, physical activity and mental health).

(d) APPROPRIATIONS.—There is authorized to be appropriated, and there is appropriated to carry out this section, $200,000,000 to be used for the 5-fiscal year period beginning with fiscal year 2011.

SA 2892. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1996, between lines 3 and 4, insert the following:

SEC. 9002. CAP ON EXCESS MEDICAL INFLATION.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new section:

"SEC. 4980J. EXCESS MEDICAL COSTS OF HEALTH BENEFITS PLANS.

''(a) GENERAL RULE.—In the case of any health benefits plan which has excess health plan costs in any plan year, there is hereby imposed a penalty equal to 40 percent of such excess health plan costs.

''(b) LIMITATION.—No penalty shall be imposed under subsection (a) with respect to a health benefits plan for a plan year if the excess health plan costs of such plan for such year is equal to or less than 0.2 percent.

''(c) EXCESS HEALTH PLAN COSTS.—For purposes of this section—

''(1) EXCESS HEALTH PLAN COSTS.—The term 'excess health plan costs' means, with respect to any health benefits plan which has an excess medical inflation rate in excess of 0.2 percent for any year, the product of—

''(A) the applicable premium of such health benefits plan for such year, and

''(B) the excess medical inflation rate for such plan for such year.

''(2) EXCESS MEDICAL INFLATION RATE.—The term 'excess medical inflation rate' means, with respect to any health benefits plan for any year, the amount equal to the excess of—

''(A) the core medical inflation trend rate of such health benefits plan for such year, over

''(B) the medical inflation cap for such year.

''(3) CORE MEDICAL TREND RATE.—The term 'core medical trend rate' means, with respect to any health benefits plan for any year, the amount (expressed as a percentage), if any, by which—

''(A) the actuarially adjusted premium of such plan for such plan for such year, exceeds

''(B) the applicable premium of such plan for the preceding plan year.

''(4) MEDICAL INFLATION CAP.—

''(A) YEARS 2013 TO 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2012 and before 2020, the medical inflation cap shall be the sum of—

''(I) the annualized rate of growth of the gross domestic product for the preceding calendar year (as calculated in the third quarter of the preceding year), plus

''(II) the applicable amount.

''(ii) APPLICABLE AMOUNT.—For purposes of clause (i)(II), the applicable amount shall be determined as follows:

''In the case of a plan year beginning in calendar year—	The applicable amount is—
2013	2.7 percentage points
2014	2.4 percentage points
2015	2.1 percentage points
2016	1.8 percentage points
2017, 2018, or 2019	1.5 percentage points

''(B) YEARS AFTER 2019.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2019, the medical inflation cap shall be equal to the amount (expressed as a percentage), if any, by which—

''(I) the average applicable premium for a low-cost plan for such calendar year, exceeds

''(II) the average applicable premium for a low-cost plan for the preceding calendar year.

''(ii) AVERAGE APPLICABLE PREMIUM FOR A LOW-COST PLAN.—For purposes of this subparagraph, the term 'average applicable premium for a low-cost plan' means the average of the applicable premiums for health benefits plans with applicable premiums below the 33rd percentile, determined by weighting such health benefits plans by the number of individuals enrolled in the plan.

''(d) APPLICABLE PREMIUM; ACTUARIALLY ADJUSTED PREMIUM.—For purposes of this section—

''(1) APPLICABLE PREMIUM.—The term 'applicable premium' has the meaning given such term under section 4980B(f)(4).

''(2) ACTUARIALLY ADJUSTED PREMIUM.—

''(A) IN GENERAL.—The term 'actuarially adjusted premium' means, for any health benefits plan for any year, the applicable premium for such year adjusted, according to actuarial standards and the method prescribed by the Secretary under subparagraph (B), by excluding any cost attributable to—

''(i) the attributes of individuals (such as age, gender, and health risk measures) covered under the plan,

''(ii) the different categories of family structure covered under the plan (such as the policies with self-only coverage, family coverage, or other categories of coverage), and

''(iii) changes in benefits or cost-sharing that result in changes the actuarial value of the plan.

''(B) METHODOLOGY.—The Secretary, in consultation with the Secretary of Health and Human Services, shall issue regulations establishing a standard methodology for adjusting a health benefits plan's applicable premiums under subparagraph (A). In the case of any change described in subparagraph (A)(iii), premiums shall be adjusted so that the calculation of the core medical trend rate is made as a comparison between two actuarially equivalent plans.

''(e) LIABILITY FOR PENALTIES.—

''(1) IN GENERAL.—Each coverage provider shall pay the penalty imposed by subsection (a).

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—In the case of a health benefits plan provided under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) OTHER COVERAGE.—In the case of any other health benefits plan, the person that administers the plan benefits.

''(f) EXEMPTIONS.—

''(1) NEW INSURERS AND NEW EMPLOYERS.—This section shall not apply to any health benefits plan which has provided coverage for less than 12 months.

''(2) FIXED INDEMNITY HEALTH COVERAGE PURCHASED WITH AFTER-TAX DOLLARS.—This section shall not apply to any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

''(3) CERTAIN GOVERNMENT PLANS.—This section shall not apply to the following:

''(A) MEDICARE.—Coverage under part A, part B, part C, or part D of title XVIII of the Social Security Act.

''(B) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

''(C) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

''(D) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1705(a) of such title.

''(4) LOW-COST PLANS.—

''(A) IN GENERAL.—This section shall not apply to any health benefits plan for which the actuarial value for the plan year is not more than the applicable threshold.

''(B) APPLICABLE THRESHOLD.—For purposes of this paragraph, the applicable threshold means the dollar amount which is equal to the actuarial value of the health benefits plan which is at the 10th percentile of actuarial value for all health benefits plans.

''(g) OTHER DEFINITIONS AND SPECIAL RULES.—

''(1) HEALTH BENEFITS PLAN.—

''(A) IN GENERAL.—The term 'health benefits plan' means health insurance coverage and a group health plan.

''(B) GOVERNMENT PLANS INCLUDED.—Such term shall include a plan established and maintained for its civilian employees by the Government of the United States or the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms by section 9832(b).

''(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term under section 5000(b).

''(4) REGULATIONS FOR HEALTH BENEFITS PLANS WITH DIFFERENT PRODUCT LINES.—The Secretary, in consultation with the Secretary of Health and Human Services, shall prescribe by regulations a uniform method for the combination of product lines of health benefits plans of any health insurance issuer for the purpose of calculating the core medical trend rate provided that the combined core medical trend rate for such plans would not reduce the sum of the excess health plan costs determined separately with respect to each product line.

''(5) SPECIAL RULE IN THE EVENT OF A MERGER, ACQUISITION OR SELL-OFFS AMONG EMPLOYERS AND INSURERS.—In the event of any merger, acquisition, or sell-off of a health benefit plan, the core medical trend rate for such plan shall be calculated by attributing the applicable premium for the preceding plan year to the coverage of health plan members in their previous group.

''(6) ADMINISTRATION AND PROCEDURE.—Any penalty under this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by this Act, is amended by adding at the end the following new item:

''Sec. 4980J. Excess medical inflation cap.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2012.

SA 2893. Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

SEC. 3211. IMPROVEMENTS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p) of the Social Security Act, as added by section 3201, is amended—

(1) in paragraph (3)—

(A) by redesignating subparagraph (C) as subparagraph (D);

(B) in subparagraph (D), as so redesignated, by striking ''(A) or (B)'' and inserting ''(A), (B), or (C)''; and

(C) by inserting after subparagraph (B) the following new subparagraph:

''(C) A county where the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for the year is greater than 45 percent (as determined by the Secretary).''; and

(2) in paragraph (5), by striking ''$5,000,000,000'' and inserting ''$7,500,000,000''.

SA 2894. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 938, strike lines 17, 18, and 19 and insert the following:

''(A) IN GENERAL.—The term 'discounted price' means—

''(i) in the case of an applicable drug that is a biologic product, 75 percent of the negotiated price of the applicable drug of the manufacturer; and

''(ii) in the case of any other applicable drug, 50 percent of the negotiated price of the applicable drug of the manufacturer.

SA 2895. Mr. BROWN (for himself, Mr. SCHUMER, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1906, between lines 5 and 6, insert the following:

(i) BIOLOGICAL PRODUCT EXCLUSIVITY PERIOD.—

(1) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.—Section 351 of the Public Health Service Act (as amended by subsections (a) and (g)), is further amended—

(A) in subsection (k)(7), by striking subparagraph (A) and inserting the following:

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—

''(i) IN GENERAL.—Approval of an application under this subsection may not be made effective by the Secretary until the earlier of—

''(I) the date that is 12 years after the date on which the reference product was first licensed under subsection (a); or

''(II) the date on which the Secretary determines that the gross sales in the United States of the reference product equals or exceeds $3,500,000,000.

''(ii) ANNUAL REPORTING.—As a condition for receiving the period of exclusivity described in clause (i), a person who receives a license for a biological product under subsection (a) shall, not later than January 31 of each year, report to the Secretary the amount of the annual gross sales in the United States in the preceding calendar year for such biological product.''; and

(B) in subsection (m)(2)(A), by striking ''12 years and 6 months rather than 12 years'' and inserting ''the date that is 6 months after the date described in subsection (k)(7)(A)(i) rather than the date described in such subsection.''.

(2) CONFORMING AMENDMENT.—Section 7002(h)(2) of this Act is amended by striking ''the 12-year period described in subsection (k)(7) of such section 351'' and inserting ''the period of exclusivity described in subsection (k)(7)(A)(i) of such section 351''.

SA 2896. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 128, between lines 6 and 7, insert the following:

(e) MEDICAL LOSS RATIO.—The Secretary shall develop a definition for the term ''medical loss ratio'', and provide standards for such term, including methods for calculating loss ratios and determinations of what constitutes an administrative cost.

SEC. 1305. HEALTH INSURANCE REPORT CARDS.

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary shall develop a standardized health insurance report card.

(b) STANDARDS.—The report card described in subsection (a) shall provide measures of the performance of qualified health plans with regard to—

(1) the adequacy of the provider network;

(2) the timeliness and accuracy of payment of claims, measured with regard to claims overall and claims associated with selected health conditions and medical services;

(3) appeals and grievance procedures;

(4) adherence to fair marketing practices;

(5) satisfaction of minimum medical loss ratios;

(6) non-discrimination on the basis of health status;

(7) quality measures, as determined by the Secretary;

(8) renewal rate increases; and

(9) other factors, as the Secretary determines appropriate.

(c) DATA COLLECTION.—The Secretary shall, in cooperation with State insurance regulators, collect data for the purpose of determining the performance of qualified health plans with regard to the standards described in subsection (b).

(d) REPORT CARDS.—The data collected under subsection (c) shall be compiled into a standardized health insurance report card, described in subsection (a), and shall be made available to consumers for the purpose of facilitating health plan comparison and choice, including by making such report cards available through the Internet portal established under section 1103(a).

(e) USE OF HEALTH PLAN REPORT CARDS BY THE SECRETARY.—The Secretary—

(1) may use the data collected under subsection (c) for administrative purposes;

(2) shall use such data to determine unreasonable increases in premiums for health insurance coverage, which may trigger action by the Secretary, such as imposing premium rebates or other sanctions, as appropriate; and

(3) may share such data with State insurance regulators, the Secretary of the Treasury, and the Secretary of Labor, for purposes of oversight and enforcement of the requirements under this title, including sharing such data with administrators of the Exchanges and using such data in negotiations with health insurance issuers over the terms of participation in such Exchanges.

SA 2897. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1529, between lines 2 and 3, insert the following:

SEC. 1572. INCREASED FUNDING FOR WORKFORCE PROGRAMS; LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

(a) LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.—

(1) IN GENERAL.—Section 274 of the Internal Revenue Code of 1986 (relating to disallowance of certain entertainment, etc., expenses) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) LIMITATION ON DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.—The amount allowable as a deduction under this chapter for expenses relating to direct to consumer advertising in any media of prescription pharmaceuticals shall not exceed 30 percent of the amount of such expenses which would (but for this paragraph) be allowable as a deduction under this chapter.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred after December 31, 2009, in taxable years ending after such date.

(b) HEALTH PROFESSIONALS TRAINING FOR DIVERSITY.—Section 740(a) of the Public Health Service Act, as amended by section 5402, is further amended by striking ''$51,000,000'' and inserting ''$100,000,000''.

(c) TEACHING HEALTH CENTERS.—Section 340H(g) of the Public Health Service Act, as added by section 5508, is amended by striking ''$230,000,000'' and inserting ''$460,000,000''.

(d) NATIONAL HEALTH SERVICE CORPS.—Section 338H of the Public Health Service Act, as amended by section 5207, is further amended by striking ''$320,461,632'' and inserting ''$600,000,000''.

(e) PRIMARY CARE TRAINING AND ENHANCEMENT.—Section 747 of the Public Health Service Act, as amended by section 5301, is further amended by striking ''$125,000,000'' and inserting ''$250,000,000''.

(f) TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.—Section 748 of the Public Health Service Act, as added by section 5303, is amended by striking ''$30,000,000'' and inserting ''$60,000,000''.

(g) PRIMARY CARE EXTENSION PROGRAM.—Section 399W(f) of the Public Health Service Act, as added by section 5405, is amended by striking ''$120,000,000'' and inserting ''$240,000,000''.

SA 2898. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1134, between lines 3 and 4, insert the following:

Subtitle G—Additional Health Care Quality and Efficiency Improvements

SEC. 3601. REPORT ON DEMONSTRATION AND PILOT PROGRAMS.

(a) REPORT.—Not later than 12 months after the date of enactment of this Act, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a report that describes all pilot programs and demonstration projects that the Secretary has authority to carry out (regardless of whether such programs or projects are actually implemented), as authorized by law, during the period for which the report is submitted.

(b) REQUIREMENTS.—A report under subsection (a) shall—

(1) list all pilot programs or demonstration projects involved and indicate whether each program or project is—

(A) not yet being implemented;

(B) currently being implemented; or

(C) complete and awaiting further determinations; and

(2) with respect to programs or projects described in subparagraphs (A) or (B) of paragraph (1), include the recommendations of the Secretary as to whether such programs or projects are necessary.

(c) ACTIONS BASED ON RECOMMENDATIONS.—Based on the recommendations of the Secretary under subsection (b)(2)—

(1) if the Secretary determines that a program or project is necessary, the Secretary shall submit to Congress a strategic plan for the implementation of the program or project and may transfer such program or project into the jurisdiction of the Innovation Center of the Centers for Medicare & Medicaid Services; or

(2) if the Secretary determines that a program or project is unnecessary, the Secretary may terminate the program.

(d) ACTION BY CONGRESS.—Congress may continue in effect any program or project terminated by the Secretary under subsection (c)(2) through the enactment of a Concurrent Resolution expressing the sense of Congress to continue the program or project involved.

SEC. 3602. AVAILABILITY OF DATA ON DENIAL OF CLAIMS.

Section 2715(b)(3) of the Public Health Service Act, as added by section 1001, is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) by redesignating subparagraph (I) as subparagraph (J): and

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) a statement relating to claims procedures including the percentage of claims that are annually denied by the plan or coverage and the percentage of such denials that are overturned on appeal; and''.

SEC. 3603. ACCELERATION AND INCREASE OF THE PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

Section 1886(p) of the Social Security Act (42 U.S.C. 1395(p)), as added by section 3008(a), is amended—

(1) in paragraph (1)—

(A) by striking ''2015'' and inserting ''2013''; and

(B) by striking ''99 percent'' and inserting ''98 percent''; and

(2) in paragraph (5), by striking ''2015'' and inserting ''2013''.

SEC. 3604. IMPROVEMENTS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in subsection (a)(3), by striking ''January 1, 2013'' and inserting ''January 1, 2012''; and

(2) by amending subsection (g) to read as follows:

''(g) AUTHORITY TO EXPAND IMPLEMENTATION.—

''(1) IN GENERAL.—Taking into account the evaluation under subparagraph (e), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of the pilot program, to the extent determined appropriate by the Secretary, if—

''(A) the Secretary determines that such expansion is expected to—

''(i) reduce spending under this title without reducing the quality of care; or

''(ii) improve the quality of care and reduce spending; and

''(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under this title.

''(2) IMPLEMENTATION PLAN.—In the case where the Secretary does not exercise the authority under paragraph (1) by January 1, 2015, not later than such date, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.''.

SEC. 3605. ENCOURAGING MEDICARE BENEFICIARIES TO CHOOSE HIGH PERFORMING PROVIDERS.

(a) AUTHORIZATION TO ESTABLISH A PILOT PROGRAM TO ENCOURAGE CHOICE OF HIGH PERFORMING PROVIDERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may establish a pilot program under which Medicare beneficiaries are encouraged to choose high performing providers under the Medicare program under title XVIII of the Social Security Act.

(2) CONSIDERATION OF MEDICARE VALUE-BASED PURCHASING REFORMS.—If the Secretary establishes a pilot program under paragraph (1), the Secretary shall, as the Secretary determines appropriate, take into consideration information obtained under value-based purchasing reforms implemented under the Medicare program, including such reforms under the provisions of and amendments made by this Act, in establishing such pilot program.

(b) DEVELOPMENT OF PHYSICIAN COMPARE INTERNET WEBSITE.—

(1) IN GENERAL.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website for use by Medicare beneficiaries to access quality and utilization data with respect to physicians (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))) participating in the Medicare program.

(2) INFORMATION AVAILABLE.—Information shall be made available on such Internet website on an ongoing basis as follows:

(A) Not later than January 1, 2011 (and for each subsequent year before 2015), the Internet website shall include information regarding which physicians received an incentive payment for quality reporting under section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) of the Social Security Act for the preceding year (and, beginning with 2015, which physicians received an incentive payment adjustment under section 1848(a)(8) of such Act, as added by section 3002(b) for the year).

(B) On or after January 1, 2013, the Internet website may, as determined appropriate by the Secretary, include information on the utilization rates of physicians, as determined for purposes of section 1848(a)(9) of such Act, as added by section 3003.

(C) On or after January 1, 2014, the Internet website may, as determined appropriate by the Secretary, include information on quality measures selected by the Secretary, in consultation with the Physician Payment Advisory Committee, from among measures reported under the physician reporting system under section 1848(k) of such Act (42 U.S.C. 1395w–4(k)).

(D) On or after January 1, 2017, the Internet website shall include results of the application of the value-based payment modifier established under section 1848(p) of the Social Security Act, as added by section 3007, together with the results of any similar provisions under title XVIII of such Act, in order for Medicare beneficiaries to see how the quality and cost of services furnished by physicians compares to the quality and cost of services furnished by their peers. Such information should, if the Secretary determines appropriate, identify physicians performing in the top 50, 60, 70, and 80th percentiles as compared to their peers.

(3) REPORT TO CONGRESS.—Not later than January 1, 2019, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under this subsection, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) EXPANSION.—At any time before the date on which the report is submitted under paragraph (3), the Secretary may expand (including expansion to other providers of services and suppliers under part B of title XVIII of the Social Security Act) the information made available on such website if the Secretary determines such expansion would improve the quality of care and reduce spending under such title.

(c) PROVIDING FINANCIAL INCENTIVES TO BENEFICIARIES UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.—Section 1115A(b)(2)(B) of the Social Security Act, as added by section 3021, is amended by adding at the end the following new clause:

''(xix) Effective beginning on or after January 1, 2018, providing financial incentives to Medicare beneficiaries who are furnished services by high performing physicians, as determined by the Secretary, taking into consideration information made available on the Physician Compare Internet website developed under section 3009(b) of the Patient Protection and Affordable Care Act.''.

SA 2899. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ___. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

SA 2900. Mr. UDALL of New Mexico submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, insert the following:

SEC. 5316. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING PROGRAMS.

(a) IN GENERAL.—Section 768 of the Public Health Service Act (42 U.S.C. 295c) is amended to read as follows:

''SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

''(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

''(1) an accredited school of public health or school of medicine or osteopathic medicine;

''(2) an accredited public or private nonprofit hospital;

''(3) a State, local, or tribal health department; or

''(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

''(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

''(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

''(2) defray the costs of practicum experiences, as required in such a program; and

''(3) establish, maintain, or improve—

''(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

''(B) programs that improve clinical teaching in preventive medicine and public health.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.''.

(b) REAUTHORIZATION.—Section 770(a) of the Public Health Service Act (42 U.S.C. 295e(a)) is amended to read as follows:

''(a) IN GENERAL.—For the purpose of carrying out this subpart, there is authorized to be appropriated $43,000,000 for fiscal year 2011, and such sums as may be necessary for each of the fiscal years 2012 through 2015.''.

SA 2901. Mr. THUNE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Beginning on page 1925, strike line 15 and all that follows through line 15 on page 1979.

SA 2902. Ms. STABENOW submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

SA 2903. Ms. SNOWE (for herself, Mr. DURBIN, Mr. MERKLEY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 126, strike lines 10 through 16.

SA 2904. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 167, strike lines 1 through 4, and insert the following:

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(2) EXCEPTION FOR SMALL EMPLOYER MANDATES.—The provisions of, and the amendments made by, this title shall preempt any State law enacted after the date of enactment of this Act that would impose a requirement on any employer with less than 50 full-time employees to, or would impose a penalty on such an employer for failing to, offer health insurance to its employees.

SA 2905. Mrs. LINCOLN (for herself, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. FRANKEN, Mrs. BOXER, and Mr. REED) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

On page 2040, strike line 14 and insert the following:

(b) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—

(1) IN GENERAL.—Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986, as added by subsection (a), is amended by adding at the end the following new subparagraph:

''(I) DOLLAR LIMIT NOT TO EXCEED COMPENSATION OF THE PRESIDENT.—In the case of a taxable year in which the $500,000 amount in clauses (i) and (ii) of subparagraph (A) exceeds the dollar amount of the compensation received by the President under section 102 of title 3, United States Code, for such taxable year, such clauses shall be applied by substituting the dollar amount provided in such section 102 for such $500,000 amount.''.

(2) REVENUE INCREASE TO BE TRANSFERRED TO MEDICARE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended—

(A) by striking ''and'' at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting ''; and'', and

(C) by inserting after paragraph (2) the following new paragraph:

''(3) the revenues resulting from the application of section 162(m)(6) of the Internal Revenue Code of 1986, as determined by the Secretary of the Treasury or such Secretary's delegate.''.

(c) EFFECTIVE DATE.—The amendments made by

SA 2906. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 308, line 16, strike all through page 314, line 6, and insert the following:

''(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—

''(1) IN GENERAL.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but

not below zero) by the sum of the following amounts:

''(A) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 40.

''(B) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

''(2) SAFEHARBOR FOR GROWING EMPLOYERS.—

''(A) IN GENERAL.—Notwithstanding paragraph (1) and except as provided in subparagraph (B), the amount of the credit determined under subsection (b) for any taxpayer for the second or third taxable year of the credit period for such taxpayer shall not be reduced by an amount greater than the amount by which it would be reduced if such reduction amount were determined by using the same fractions determined under paragraph (1) for the first taxable year of such credit period.

''(B) REDUCTION IN AGGREGATE AMOUNT OF CONTRIBUTIONS.—For purposes of determining the amount of the credit under subsection (b) for any taxpayer to whom subparagraph (A) applies for any taxable year of the taxpayer in the credit period after the first such taxable year, the amount of the nonelective contributions made on behalf of any employee whose annual wages exceed twice the dollar amount in effect under subsection (d)(3)(B) for such taxable year which may be taken into account under subsection (b) shall not exceed such annual wages multiplied by a fraction the numerator of which is twice the dollar amount so in effect and the denominator of which is such annual wages.

''(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any taxable year, an employer—

''(A) which has no more than 50 full-time equivalent employees for the taxable year,

''(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

''(C) which has in effect an arrangement described in paragraph (4).

Notwithstanding subparagraphs (A) and (B), an employer which is an eligible small employer for the first taxable year in a credit period shall be treated as an eligible small employer for the remaining taxable years in such credit period.

''(2) FULL-TIME EQUIVALENT EMPLOYEES.—

''(A) IN GENERAL.—The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing—

''(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

''(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

''(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

''(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

''(3) AVERAGE ANNUAL WAGES.—

''(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

''(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

''(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

''(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $25,000.

''(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $25,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

''(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

''(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

''(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

''(B) DEFINITION OF SEASONAL WORKER.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

''(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

''(1) EMPLOYEE.—

''(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—

''(i) an employee within the meaning of section 401(c)(1),

''(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

''(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

''(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

''(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

''(2) CREDIT PERIOD.—The term 'credit period' means, with respect to any eligible small employer, the 3-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

SA 2907. Ms. KLOBUCHAR (for herself, Mr. THUNE, and Mr. JOHNSON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 828, between lines 3 and 4, insert the following:

SEC. 3130. REMOTE MONITORING PILOT PROJECTS.

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct pilot projects under title XVIII of the Social Security Act for the purpose of providing incentives to home health agencies to utilize home monitoring and communications technologies that—

(A) enhance health outcomes for medicare beneficiaries; and

(B) reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 1 of the pilot projects in a State with a population of less than 1,000,000.

(3) DEFINITION OF HOME HEALTH AGENCY.—In this section, the term ''home health agency'' has the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(b) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—The Secretary shall specify the criteria for identifying those medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects of medicare beneficiaries who begin receiving home health services under title XVIII of the Social Security Act after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency—

(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act for medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk and adjusted growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts A and B during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the medicare savings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act, the Secretary may initiate comparable projects in additional areas.

(g) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SA 2908. Ms. KLOBUCHAR (for herself and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 492, between lines 15 and 16, insert the following:

SEC. 2407. SUPPORT FOR FAMILY CAREGIVERS UNDER MEDICARE AND MEDICAID.

(a) MEDICARE FAMILY CAREGIVER INFORMATION AND REFERRAL.—State health insurance assistance programs, the Administrator of the Centers for Medicare & Medicaid Services, and the Assistant Secretary of the Administration on Aging shall, in collaboration with each other, directly or by contract, develop practical, easy-to-understand information and referral protocols for health care providers, social workers, and other appropriate individuals to provide to family caregivers of Medicare beneficiaries either on admission to or discharge from a hospital (including a discharge from a hospital emergency room or a hospital outpatient department which has furnished a surgical service) or a post-acute care setting (including a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)), a comprehensive rehabilitation facility (as defined in section 1861(cc)(2) of such Act (42 U.S.C. 1395x(cc)(2)) or a rehabilitation agency, a provider of long-term care services, and a home health agency (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o)). Information developed under the preceding sentence shall—

(1) include information on national, State, and community-based resources for seniors, individuals with disabilities and their caregivers, which shall be updated on a semi-annual basis (or as frequently as practicable);

(2) be disseminated by health care providers, social workers, and other appropriate individuals as printed materials (including materials in Spanish and other languages (other than English) as appropriate); and

(3) be made available on the Internet websites of State health insurance assistance programs, the Centers for Medicare & Medicaid Services, and the Administration on Aging.

(b) MEDICAID ASSESSMENT OF FAMILY CAREGIVER SUPPORT NEEDS.—

(1) IN GENERAL.—Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 2401, is amended—

(A) in subsection (c)(2)—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(F) under such waiver the State may provide for an assessment of family caregiver support needs (in accordance with subsection (l)).'';

(B) in subsection (d)(2)—

(i) in subparagraph (B), by striking ''and'' at the end;

(ii) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(D) under such waiver the State may provide for an assessment of family caregiver support needs (in accordance with subsection (l)).'';

(C) in subsection (i)(1)(F), by adding at the end the following new clause:

''(vii) Where appropriate, an assessment of family caregiver support needs (in accordance with subsection (l)).''; and

(D) by adding at the end the following new subsection:

''(l) ASSESSMENT OF FAMILY CAREGIVER SUPPORT NEEDS.—

''(1) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services under a waiver under subsection (c) or (d) or under section 1115, under a State plan amendment under subsection (i), under an MFP demonstration project established under section 6071 of the Deficit Reduction Act of 2005, or as part of self-directed personal assistance services provided pursuant to a written plan of care in accordance with the requirements of subsection (j), and who is dependent upon the assistance of a family caregiver, the State may provide for an assessment of the family caregiver support needs of the individual. Such assessment shall, to the extent feasible, be conducted at the same time as, or closely coordinated with, the determination of the eligibility of the individual for such services.

''(2) QUESTIONNAIRE.—

''(A) IN GENERAL.—Such assessment shall include asking the family caregiver of the individual questions in order to determine whether they would benefit from targeted support services (such as those services described in paragraph (3)).

''(B) COMPLETION ON A VOLUNTARY BASIS.—The answering of questions under subparagraph (A) by a family caregiver shall be on a voluntary basis.

''(3) TARGETED SUPPORT SERVICES DESCRIBED.—The following targeted support services are described in this paragraph:

''(A) Respite care and emergency back-up services (including short-term help for the individual that gives the family caregiver a break from providing such care).

''(B) Individual counseling (including advice and consultation sessions to bolster emotional support for the family caregiver to make well-informed decisions about how to cope with the strain of supporting the individual).

''(C) Support groups, including groups which provide help for family caregivers to—

''(i) locate a support group either locally or online to share experiences and reduce isolation;

''(ii) make well-informed decisions about caring for the individual; and

''(iii) reduce isolation.

''(D) Information and assistance (including brochures and online resources for researching a disease or disability or learning and managing a regular caregiving role, new technologies that can assist family caregivers, and practical assistance for locating services).

''(E) Chore services (such as house cleaning).

''(F) Personal care (including outside help).

''(G) Education and training (including workshops and other resources available with information about stress management, self-care to maintain good physical and mental health, understanding and communicating with individuals with dementia, medication management, normal aging processes, change in disease and disability, the role of assistive technologies, and other relevant topics).

''(H) Legal and financial planning and consultation (including advice and counseling regarding long-term care planning, estate planning, powers of attorney, community property laws, tax advice, employment leave advice, advance directives, and end-of-life care).

''(I) Transportation (including transportation to medical appointments).

''(J) Other targeted support services the Secretary or the State determines appropriate.

''(4) REFERRALS.—In the case where a questionnaire completed by a family caregiver under paragraph (2) indicates that the family caregiver would benefit from 1 or more of the targeted support services described in paragraph (3), the State shall provide referrals to the family caregiver for local, State, and private-sector family caregiver programs and other resources that provide such targeted support services.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to medical assistance for home and community-based services that is provided on or after the date of enactment of this Act.

SA 2909. Mr. NELSON of Florida (for himself, Mr. REID, Mr. SCHUMER, Mr. KERRY, Ms. STABENOW, and Mr. LEAHY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees,

and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1449, strike line 1 and all that follows through page 1458, line 5, and insert the following:

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)''; and

(3) by adding at the end the following new paragraph:

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) ADDITIONAL RESIDENCY POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—The Secretary shall reduce the otherwise applicable resident limit for a hospital that the Secretary determines had residency positions that were unused for all 5 of the most recent cost reporting periods ending prior to the date of enactment of this paragraph by an amount that is equal to the number of such unused residency positions.

''(II) EXCEPTION FOR RURAL HOSPITALS AND CERTAIN OTHER HOSPITALS.—This subparagraph shall not apply to a hospital—

''(aa) located in a rural area (as defined in subsection (d)(2)(D)(ii));

''(bb) that has participated in a voluntary reduction plan under paragraph (6); or

''(cc) that has participated in a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248.

''(ii) NUMBER AVAILABLE FOR DISTRIBUTION.—The number of additional residency positions available for distribution under subparagraph (B) shall be an amount that the Secretary determines would result in a 15 percent increase in the aggregate number of full-time equivalent residents in approved medical training programs (as determined based on the most recent cost reports available at the time of distribution). One-third of such number shall only be available for distribution to hospitals described in subclause (I) of subparagraph (B)(ii) under such subparagraph.

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after the date of enactment of this paragraph. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the number of additional residency positions available for distribution under subparagraph (A)(ii).

''(ii) DISTRIBUTION TO HOSPITALS ALREADY OPERATING OVER RESIDENT LIMIT.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital in which the reference resident level of the hospital (as specified in clause (iii)) is greater than the otherwise applicable resident limit, the increase in the otherwise applicable resident limit under this subparagraph shall be an amount equal to the product of the total number of additional residency positions available for distribution under subparagraph (A)(ii) and the quotient of—

''(aa) the number of resident positions by which the reference resident level of the hospital exceeds the otherwise applicable resident limit for the hospital; and

''(bb) the number of resident positions by which the reference resident level of all such hospitals with respect to which an application is approved under this subparagraph exceeds the otherwise applicable resident limit for such hospitals.

''(II) REQUIREMENTS.—A hospital described in subclause (I)—

''(aa) is not eligible for an increase in the otherwise applicable resident limit under this subparagraph unless the amount by which the reference resident level of the hospital exceeds the otherwise applicable resident limit is not less than 10 and the hospital trains at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery (as of the date of enactment of this paragraph); and

''(bb) shall continue to train at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery for the 10-year period beginning on such date.

In the case where the Secretary determines that a hospital no longer meets the requirement of item (bb), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this clause.

''(III) CLARIFICATION REGARDING ELIGIBILITY FOR OTHER ADDITIONAL RESIDENCY POSITIONS.—Nothing in this clause shall be construed as preventing a hospital described in subclause (I) from applying for additional residency positions under this paragraph that are not reserved for distribution under this clause.

''(iii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in subclause (II), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before the date of enactment of this paragraph, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAM OR ESTABLISHMENT OF NEW PROGRAM.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program or the establishment of a new residency training program that is not reflected on the most recent cost report that has been settled (or, if not, submitted (subject to audit)), subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary.

''(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2010, made available under this paragraph, as determined by the Secretary.

''(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall distribute the increase to hospitals based on the following criteria:

''(i) The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions. In the case of any increase based on such preference, a hospital shall ensure that—

''(I) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position is filled; and

''(II) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

In the case where the Secretary determines that a hospital no longer meets the requirement of subclause (II), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph.

''(ii) The Secretary shall give preference to hospitals that emphasize training in community health centers and other community-based clinical settings.

''(iii) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios). In determining the number of medical students in a State for purposes of the preceding sentence, the Secretary shall include planned students at medical schools which have provisional accreditation by the Liaison Committee on Medical Education or the American Osteopathic Association.

''(iv) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(E) LIMITATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(III)) apply for more than 50 full-time equivalent additional residency positions under this paragraph.

''(ii) INCREASE IN NUMBER OF ADDITIONAL POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

''(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(G) DISTRIBUTION.—The Secretary shall distribute the increase to hospitals under this paragraph not later than 2 years after the date of enactment of this paragraph.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after the date of enactment of this clause, insofar as an additional payment amount under this

subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

SA 2910. Mr. FRANKEN (for himself, Mr. ROCKEFELLER, Mrs. LINCOLN, Mr. WHITEHOUSE, Mr. LEAHY, Mr. SANDERS, Mr. BROWN, and Mr. BEGICH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 1003, insert the following:

SEC. 1004. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

(a) IN GENERAL.—Section 2718 of the Public Health Service Act, as added by section 1001, is amended to read as follows:

''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

''(a) CLEAR ACCOUNTING FOR COSTS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the plan or issuer on activities described in subsection (a)(3) exceeds 10 percent, or such lower percentage as a State may by regulation determine.

''(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by group health plans and health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

''(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

''(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

''(d) DEFINITIONS.—Not later than December 31, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners, shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities.''.

(b) TECHNICAL AMENDMENTS.—

(1) ERISA.—Section 715(b) of the Employee Retirement Income Security Act, as amended by section 1562(e), is further amended by striking ''sections 2716 and 2718'' and inserting ''section 2716''.

(2) IRC.—Section 9815(b) of the Internal Revenue Code of 1986 is amended by striking ''sections 2716 and 2718'' and inserting ''section 2716''.

SA 2911. Mr. FRANKEN (for himself and Mr. LUGAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title IV, insert the following:

SEC. 4208. NATIONAL DIABETES PREVENTION PROGRAM.

Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 5405, is further amended by adding at the end the following:

''SEC. 399V–2. NATIONAL DIABETES PREVENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the 'program') targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

''(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—

''(1) a grant program for community-based diabetes prevention program model sites;

''(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

''(3) a training and outreach program for lifestyle intervention instructors; and

''(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

''(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SA 2912. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. ___. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

Section 340E(g)(2) of the Public Health Service Act (42 U.S.C. 256e(g)) is amended—

(1) by striking ''means a'' and inserting ''means—

''(A) a'';

(2) by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(B) a freestanding psychiatric hospital with 90 percent or more inpatients under the age of 18, that has its own Medicare provider number as of December 6, 1999, and that has an accredited residency program.''.

SA 2913. Mr. WHITEHOUSE (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1507, after line 19, insert the following:

SEC. 5510. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.

Subpart IX of part D of title III of the Public Health Service Act (42 U.S.C. 256e et seq.) is amended—

(1) in the subpart heading, by adding ''**and Women's Hospitals**'' at the end; and

(2) by adding at the end the following:

''SEC. 340E-1. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.

''(a) PAYMENTS.—The Secretary shall make two payments under this section to each women's hospital for each of fiscal years 2010 through 2014, one for the direct expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs. The Secretary shall promulgate regulations pursuant to the rulemaking requirements of title 5, United States Code, which shall govern payments made under this subpart.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amounts payable under this section to a women's hospital for an approved graduate medical residency training program for a fiscal year shall be each of the following:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for direct expenses associated with operating approved graduate medical residency training programs for a fiscal year.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs for a fiscal year.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to women's hospitals under

paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the funds appropriated under subsection (e) for such payments for that fiscal year.

''(B) PRO RATA REDUCTIONS OF PAYMENTS FOR DIRECT EXPENSES.—If the Secretary determines that the amount of funds appropriated under subsection (e) for a fiscal year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1)(A), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

''(3) ANNUAL REPORTING REQUIRED.—The provisions of subsection (b)(3) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

''(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (c) and (d) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

''(d) MAKING OF PAYMENTS.—

''(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 12 equal interim installments during such period. Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital's most recently filed Medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established. In the case of a hospital that does not report residents on a Medicare cost report, such interim payments shall be based on the number of residents trained during the hospital's most recently completed Medicare cost report filing period.

''(2) WITHHOLDING.—The Secretary shall withhold up to 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1) as necessary to ensure a hospital will not be overpaid on an interim basis.

''(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made and pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1886(d) of such Act is subject to review under such section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $12,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(f) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(h)(5)(A) of the Social Security Act.

''(2) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term 'direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act.

''(3) WOMEN'S HOSPITAL.—The term 'women's hospital' means a hospital—

''(A) that has a Medicare provider agreement under title XVIII of the Social Security Act;

''(B) that has an approved graduate medical residency training program;

''(C) that has not been excluded from the Medicare prospective payment system;

''(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

''(E) with respect to which and as determined by the Centers for Medicare & Medicaid Services, less than 4 percent of the total discharges from the hospital during 2007 were Medicare discharges of individuals who, as of the time of the discharge—

''(i) were enrolled in the original Medicare fee-for-service program under part A of title XVIII of the Social Security Act; and

''(ii) were not enrolled in—

''(I) a Medicare Advantage plan under part C of title XVIII of that Act;

''(II) an eligible organization under section 1876 of that Act; or

''(III) a PACE program under section 1894 of that Act.''.

SA 2914. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2029, between lines 4 and 5, insert the following:

(c) PERFORMANCE ADJUSTMENT TO ANNUAL FEE.—

(1) IN GENERAL.—The Secretary shall—

(A) in the case of a penalized covered entity, increase the fee determined under subsection (b) for a calendar year as provided in paragraph (3), and

(B) in the case of any other covered entity, reduce the fee determined under subsection (b) for a calendar year as provided in paragraph (4).

(2) PENALIZED COVERED ENTITY DESCRIBED.—

(A) IN GENERAL.—For purposes of this paragraph, the term ''penalized covered entity'' means a covered entity that the Secretary determines has failed to meet the key performance thresholds (established under subparagraph (B)) for the calendar year involved.

(B) KEY PERFORMANCE THRESHOLDS.—The key performance thresholds established under this subparagraph are as follows:

(i) MEDICAL LOSS RATIO THRESHOLD.—The covered entity has a medical loss ratio, as reported under section 2718(a)(1) of the Public Health Service Act, of not less than 85 percent. The Secretary, in consultation with the Secretary of Health and Human Services may increase, but not decrease, such percentage by regulation.

(ii) MAXIMUM FINANCIAL RESERVE THRESHOLD.—

(I) IN GENERAL.—The covered entity has a financial reserve which is not greater than the amount established under regulations by the Secretary, in consultation with the Secretary of Health and Human Services. The Secretary may establish different thresholds for different categories of covered entity under this section. The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish a uniform methodology for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

(II) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulation) to the Secretary and the Secretary of Health and Human Services containing such information about the financial reserves of the entity as the Secretary may require. The rules of subsection (g)(2) shall apply to the information required to be reported under this subclause.

(3) AMOUNT OF FEE INCREASE.—

(A) IN GENERAL.—In the case of a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be increased by the penalty amount.

(B) PENALTY AMOUNT.—

(i) IN GENERAL.—The penalty amount shall be the product of—

(I) the amount determined under subsection (b), and

(II) the sum of the amounts determined under subparagraphs (C) and (D).

(ii) LIMITATION.—The penalty amount shall not exceed 20 percent of the amount determined under subsection (b).

(C) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio threshold established under paragraph (2)(A), over

(ii) the medical loss ratio (expressed in decimal form) of the penalized covered entity.

(D) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the financial reserves of the penalized covered entity, over

(II) the maximum financial reserve threshold established under paragraph (2)(B)(ii), to

(ii) such maximum financial reserve threshold.

(4) REDUCTION IN FEE.—

(A) IN GENERAL.—

(i) AMOUNT OF REDUCTION.—In the case of any covered entity that is not a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be reduced by an amount equal to the product of—

(I) the sum of all penalty amounts assessed in the calendar year under paragraph (3), and

(II) the fee redistribution ratio.

(ii) LIMITATION.—The reduction under this paragraph shall not exceed 20 percent of the amount determined under subsection (b).

(B) FEE DISTRIBUTION RATIO.—For purposes of this paragraph, the fee redistribution ratio is the ratio of—

(i) the weighted net written premium amount of the covered entity, to

(ii) the aggregate of the weighted net written premium amount of all covered entities.

(C) WEIGHTED NET WRITTEN PREMIUM AMOUNT.—For purposes of this paragraph, the weighted net written premium amount with respect to any covered entity is the amount described in subsection (b)(1)(A)(i) with respect to such covered entity, increased by the product of—

(i) such amount, and

(ii) the product of 0.05 and the sum of the amounts determined under subparagraphs (D) and (E).

(D) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio (expressed as a percentage) of the covered entity, over

(ii) the medical loss ratio threshold established under paragraph (2)(A).

(E) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the maximum financial reserve threshold established under paragraph (2)(B)(ii), over

(II) the financial reserves of the covered entity, to

(ii) such maximum financial reserve threshold.

SA 2915. Mrs. SHAHEEN (for herself, Mr. BROWN, Mr. MENENDEZ, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 531, line 2, insert the following after the period: ''In awarding planning grants, the Secretary shall give preference to States that agree to develop a State plan amendment that includes methodologies and procedures that are intended to improve coordination of care for eligible individuals with chronic conditions who are high users of health care services (including emergency room and inpatient hospital services), including through the use of referrals to health homes and outreach care management services.''

SA 2916. Mr. UDALL of New Mexico (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1539, line 7, insert ''in a rural area (as defined in section 1886(d)(2)(D)), a medically underserved community (as defined in section 799B(6) of the Public Health Service Act), or'' after ''located''.

SA 2917. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 116, between lines 6 and 7, insert the following:

(4) SPECIAL RULE REGARDING PREGNANCY.—An individual who becomes pregnant and is enrolled in a catastrophic plan described under this subsection may, notwithstanding any other provision of law, enroll in another qualified health plan during such individual's pregnancy.

SA 2918. Mr. MENENDEZ (for himself, Ms. STABENOW, and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 116, between lines 13 and 14, insert the following:

(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

SA 2919. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 33, strike line 5 and all that follows through line 4 on page 34 and insert the following:

''SEC. 2719. APPEALS PROCESS.

''(a) INTERNAL CLAIMS APPEALS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

''(1) have in effect an internal claims appeal process;

''(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

''(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

''(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

''(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

''(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

''(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

''(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).''.

SA 2920. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 1103, insert the following:

SEC. 1104. REPORTING REQUIREMENTS REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS.

(a) REQUIREMENTS REGARDING DENIAL OF COVERAGE FOR MEDICAL SERVICES.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall promulgate regulations requiring health insurance issuers to report annually to the Secretary data concerning—

(A) each denial of coverage for medical services to a plan enrollee in the preceding year, listed by the types of services for which coverage was denied; and

(B) the reasons such coverage was denied.

(2) PUBLICATION OF DATA.—The Secretary shall make the data reported under paragraph (1) available to the public on the Internet website described in section 1103(a).

(b) REQUIREMENTS REGARDING DENIAL OF ENROLLMENT IN A HEALTH INSURANCE PLAN.—

(1) IN GENERAL.—Not later than January 1, 2011, the Secretary shall issue regulations requiring each health insurance issuer to report annually to the Secretary data concerning—

(A) each incident in which such issuer, in the preceding year, denied the application of an individual to enroll in a health insurance plan offered by such issuer; and

(B) the reasons each such application was denied.

(2) PUBLICATION OF DATA.—The Secretary shall make the data reported under paragraph (1) available to the public on the Internet website described in section 1103(a).

(3) SUNSET.—The requirements under this subsection shall cease to have effect on January 1, 2014.

(c) CONSULTATION.—In developing the regulations under subsection (a)(1) and (b)(1) and collecting data as required by such subsections, the Secretary shall consult with State insurance commissioners and the National Association of Insurance Commissioners.

(d) APPLICABILITY OF REQUIREMENTS.—The reporting requirements under this section shall apply to all health insurance issuers and all health insurance plans, without regard to whether such issuer offers a qualified health plan, or whether such plan is a qualified health plan, as described in subtitle D.

SA 2921. Ms. STABENOW (for herself and Mrs. MCCASKILL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr.

REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

Subtitle C—Provisions Related to Improving Tax Incentives for Individuals and Employers Under Title I

PART I—GENERAL PROVISIONS

SEC. 9031. PREMIUM ASSISTANCE CREDIT.

(a) IN GENERAL.—Section 36B(b)(3)(A)(i) of the Internal Revenue Code of 1986, as added by section 1401, is amended by striking ''7'' each place it appears and inserting ''6''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in section 1401.

SEC. 9032. SMALL EMPLOYER HEALTH INSURANCE CREDIT.

(a) IN GENERAL.—Notwithstanding section 1421(f) of this Act—

(1) the amendments made by subsections (a), (b), (d), and (e) of section 1421 shall apply to taxable years beginning after December 31, 2009, and

(2) the amendments made by subsection (c) of section 1421 shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2009.

(b) CONFORMING AMENDMENTS.—

(1) Clause (i) of section 45R(d)(3)(B) of the Internal Revenue Code of 1986, as added by section 1421, is amended by inserting ''2010,'' before ''2011'' each place it appears in the text and in the heading.

(2) Subsection (g) of section 45R of such Code, as added by section 1421, is amended by inserting ''2010,'' before ''2011'' each place it appears in the text and in the heading.

(3) Section 280C(h) of such Code, as added by section 1421, is amended by inserting ''2010,'' before ''2011''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2009.

PART II—REVENUE PROVISIONS

SEC. 9035. SURTAX ON INVESTMENT INCOME.

(a) IN GENERAL.—

(1) SURTAX.—

(A) IMPOSITION OF TAX.—Subtitle A of the Internal Revenue Code of 1986 is amended by redesignating chapter 3 as chapter 4 and by inserting after chapter 2 the following new chapter:

''CHAPTER 3—TAX ON INVESTMENT INCOME

''Sec. 1411. Rate of tax.
''Sec. 1412. Investment income.

''SEC. 1411. RATE OF TAX.

''(a) IN GENERAL.—In addition to other taxes, there shall be imposed for each taxable year on the investment income of every taxpayer (other than a corporation, estate, or trust) a tax equal to 1.45 percent of such investment income for such taxable year.

''(b) PHASE-IN OF RATE.—The rate under subsection (a) (determined without regard to this subsection) shall be reduced (but not below zero) by the amount which bears the same ratio to such rate as—

''(1) the excess of—

''(A) $240,000 ($290,000 in the case of a joint return), over

''(B) the taxpayer's adjusted gross income for the taxable year, bears to

''(2) $40,000.

''SEC. 1412. INVESTMENT INCOME.

''(a) IN GENERAL.—For purposes of this chapter, the term 'investment income' means the sum of—

''(1) capital gain net income, and

''(2) net investment income.

''(b) NET INVESTMENT INCOME.—For purposes of this chapter, the term 'net investment income' means the net income (other than income which is included in self-employment income for purposes of chapter 2) from—

''(1) dividends,

''(2) interest (other than interest which is excludable from income under chapter 1), and

''(3) investment property income.

''(c) INVESTMENT PROPERTY.—For purposes of this chapter, the term 'investment property income' means income (determined after taking into account any deduction allowed under chapter 1 with respect to such income) derived from—

''(1) any property held for the production of rents or royalties,

''(2) any partnership or S corporation,

''(3) any estate or trust in which the taxpayer is a beneficiary, and

''(4) any real estate mortgage investment conduit in which the taxpayer is a residual holder.

''(d) TAXABLE YEARS ENDING AS THE RESULT OF A DEATH.—Rules similar to the rules of section 1402(f) shall apply with respect to investment income in a taxable year which ends as a result of the death of the taxpayer.''.

(2) ESTIMATED TAXES.—Section 6654 of the Internal Revenue Code of 1986 is amended —

(A) in subsection (a), by striking ''and the tax under chapter 2'' and inserting ''the tax under chapter 2, and the tax under chapter 3'', and

(B) in subsection (f)—

(i) by striking ''minus'' at the end of paragraph (2) and inserting ''plus'', and

(ii) by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

''(3) the taxed imposed by chapter 3, minus''.

(3) RETURNS.—

(A) IN GENERAL.—Subpart B of part II of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 6017A. INVESTMENT INCOME TAX RETURNS.

''Every taxpayer (other than a corporation, estate, or trust) having investment income for the taxable year shall make a return with respect to the investment income tax imposed by chapter 3.''.

(B) CONFORMING AMENDMENT.—The table of sections for subpart B of part II of subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

''Sec. 6017A. Investment income tax returns.''.

(4) CONFORMING AMENDMENTS.—

(A) The following sections of the Internal Revenue Code of 1986 are amended by striking ''chapter 3'' and inserting ''chapter 4'' each place it appears:

(i) Section 33.
(ii) Section 864(b).
(iii) Section 871(k)(1)(B)(ii).
(iv) Section 877A(d)(5).
(v) Section 896(a).
(vi) Section 3402(t)(2)(A).
(vii) Section 3405(e)(1)(B)(iii).
(viii) Paragraphs (2)(C)(iv), (5)(A), and (5)(B) of section 6049(b).
(ix) Section 6414.
(x) Paragraphs (1) and (2) of section 6501(b).
(xi) Subsections (b)(3) and (c) of section 6513.
(xii) Paragraphs (1) and (2) of section 6724(d).

(B) CLERICAL AMENDMENT.—The table of chapters for subtitle A of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating the item relating to chapter 3 as relating to chapter 4 and by inserting after the item relating to chapter 2 the following new item:

''CHAPTER 3—TAX ON INVESTMENT INCOME''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2012.

(b) TRANSFER OF AMOUNTS TO FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended by striking ''and'' at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting ''; and'', and by inserting after paragraph (2) the following new paragraph:

''(3) the taxes imposed by section 1411 of the Internal Revenue Code of 1986 with respect to investment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such investment income, which investment income shall be certified by the Commissioner of Social Security on the basis of records of investment income established and maintained by the Commissioner of Social Security.''.

SA 2922. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 567, after line 19, add the following:

SEC. 2903. FUNDING FOR CONTRACT MEDICAL CARE FOR INDIANS.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding at the end the following:

''SEC. 826. FUNDING FOR CONTRACT MEDICAL CARE.

''(a) APPROPRIATION.—For the purpose of the Secretary, acting through the Service, providing payment for contract medical care to Indians, there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed—

''(1) for fiscal year 2010, $625,000,000;

''(2) for fiscal year 2011, $2,500,000,000;

''(3) for each of fiscal years 2012 through 2014, the limit specified under this subsection for the preceding fiscal year, increased by the percentage increase (if any) in the medical care component of the Consumer Price Index for All Urban Consumers (all items; United States city average) over such preceding fiscal year; and

''(4) for the first quarter of fiscal year 2015, one-fourth of the limit specified under this subsection for fiscal year 2014, increased by the percentage increase (if any) in the medical care component of the Consumer Price Index for All Urban Consumers (all items; United States city average) over such preceding fiscal year.

''(b) NO EFFECT ON OTHER FUNDING FOR THIS ACT; AVAILABILITY.—Funds appropriated under subsection (a) shall—

''(1) be in addition to any other amounts made available under law (including under a

provision of this Act, the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or any other law) for payment for providing contract medical care to Indians; and

''(2) remain available until expended.

''(c) STUDY AND REPORT.—Not later than October 1, 2015, the Secretary shall study and submit a report to the Committee on Natural Resources of the House of Representatives and the Committee on Indian Affairs of the Senate on the extent to which the funds appropriated under this section have assisted in reducing health disparities among Indians.

''(d) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for payment of the amounts provided under subsection (a).

''(e) DEFINITION.—In this section, the term 'Indian health program' means—

''(1) any health program administered directly by the Service;

''(2) any tribal health program; and

''(3) any Indian tribe or tribal organization to which the Secretary of Health and Human Services provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').''.

SA 2923. Mr. DORGAN (for himself, Mr. WHITEHOUSE, Mr. UDALL of New Mexico, Mr. BEGICH, Mr. JOHNSON, Mr. FRANKEN, Ms. CANTWELL, Mr. UDALL of Colorado, Mr. TESTER, and Mr. INOUYE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, add the following:

DIVISION B—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND EXTENSION

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Health Care Improvement Reauthorization and Extension Act of 2009''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND AMENDMENTS

SEC. 101. REAUTHORIZATION.

(a) IN GENERAL.—Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680o) is amended to read as follows:

''SEC. 825. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2010 and each fiscal year thereafter, to remain available until expended.''.

(b) REPEALS.—The following provisions of the Indian Health Care Improvement Act are repealed:

(1) Section 123 (25 U.S.C. 1616p).

(2) Paragraph (6) of section 209(m) (25 U.S.C. 1621h(m)).

(3) Subsection (g) of section 211 (25 U.S.C. 1621j).

(4) Subsection (e) of section 216 (25 U.S.C. 1621o).

(5) Section 224 (25 U.S.C. 1621w).

(6) Section 309 (25 U.S.C. 1638a).

(7) Section 407 (25 U.S.C. 1647).

(8) Subsection (c) of section 512 (25 U.S.C. 1660b).

(9) Section 514 (25 U.S.C. 1660d).

(10) Section 603 (25 U.S.C. 1663).

(11) Section 805 (25 U.S.C. 1675).

(c) CONFORMING AMENDMENTS.—

(1) Section 204(c)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1621c(c)(1)) is amended by striking ''through fiscal year 2000''.

(2) Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621*l*) is amended by striking ''(a) The Secretary'' and inserting ''The Secretary''.

(3) Section 310 of the Indian Health Care Improvement Act (25 U.S.C. 1638b) is amended by striking ''funds provided pursuant to the authorization contained in section 309'' each place it appears and inserting ''funds made available to carry out this title''.

SEC. 102. FINDINGS.

Section 2 of the Indian Health Care Improvement Act (25 U.S.C. 1601) is amended—

(1) by redesignating subsections (a), (b), (c), and (d) as paragraphs (1), (3), (4), and (5), respectively, and indenting the paragraphs appropriately; and

(2) by inserting after paragraph (1) (as so redesignated) the following:

''(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.''.

SEC. 103. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

Section 3 of the Indian Health Care Improvement Act (25 U.S.C. 1602) is amended to read as follows:

"SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

''Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

''(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

''(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

''(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;

''(5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;

''(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

''(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.''.

SEC. 104. DEFINITIONS.

Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) is amended—

(1) by striking the matter preceding subsection (a) and inserting ''In this Act:'';

(2) in each of subsections (c), (j), (k), and (l), by redesignating the paragraphs contained in the subsections as subparagraphs and indenting the subparagraphs appropriately;

(3) by redesignating subsections (a) through (q) as paragraphs (17), (18), (13), (14), (26), (28), (27), (29), (1), (20), (11), (7), (19), (10), (21), (8), and (9), respectively, indenting the paragraphs appropriately, and moving the paragraphs so as to appear in numerical order;

(4) in each paragraph (as so redesignated), by inserting a heading the text of which is comprised of the term defined in the paragraph;

(5) by inserting ''The term'' after each paragraph heading;

(6) by inserting after paragraph (1) (as redesignated by paragraph (3)) the following:

''(2) BEHAVIORAL HEALTH.—

''(A) IN GENERAL.—The term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

''(B) INCLUSIONS.—The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(3) CALIFORNIA INDIAN.—The term 'California Indian' means any Indian who is eligible for health services provided by the Service pursuant to section 809.

''(4) COMMUNITY COLLEGE.—The term 'community college' means—

''(A) a tribal college or university; or

''(B) a junior or community college.

''(5) CONTRACT HEALTH SERVICE.—The term 'contract health service' means any health service that is—

''(A) delivered based on a referral by, or at the expense of, an Indian health program; and

''(B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

''(6) DEPARTMENT.—The term 'Department', unless otherwise designated, means the Department of Health and Human Services.'';

(7) by striking paragraph (7) (as redesignated by paragraph (3)) and inserting the following:

''(7) DISEASE PREVENTION.—

''(A) IN GENERAL.—The term 'disease prevention' means any activity for—

''(i) the reduction, limitation, and prevention of—

''(I) disease; and

''(II) complications of disease; and

''(ii) the reduction of consequences of disease.

''(B) INCLUSIONS.—The term 'disease prevention' includes an activity for—

''(i) controlling—

''(I) the development of diabetes;

''(II) high blood pressure;

''(III) infectious agents;

''(IV) injuries;

''(V) occupational hazards and disabilities;

''(VI) sexually transmittable diseases; or

''(VII) toxic agents; or

''(ii) providing—

''(I) fluoridation of water; or

''(II) immunizations.'';

(8) by striking paragraph (9) (as redesignated by paragraph (3)) and inserting the following:

''(9) FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

''(A) Central nervous system involvement such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(C) Prenatal or postnatal growth delay.'';

(9) by striking paragraphs (11) and (12) (as redesignated by paragraph (3)) and inserting the following:

''(11) HEALTH PROMOTION.—The term 'health promotion' means any activity for—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness regarding health matters and enabling individuals to cope with health problems by increasing knowledge and providing valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in accordance with physical and mental capacity;

''(D) making available safe water and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting culturally competent care; and

''(G) providing adequate and appropriate programs, including programs for—

''(i) abuse prevention (mental and physical);

''(ii) community health;

''(iii) community safety;

''(iv) consumer health education;

''(v) diet and nutrition;

''(vi) immunization and other methods of prevention of communicable diseases, including HIV/AIDS;

''(vii) environmental health;

''(viii) exercise and physical fitness;

''(ix) avoidance of fetal alcohol spectrum disorders;

''(x) first aid and CPR education;

''(xi) human growth and development;

''(xii) injury prevention and personal safety;

''(xiii) behavioral health;

''(xiv) monitoring of disease indicators between health care provider visits through appropriate means, including Internet-based health care management systems;

''(xv) personal health and wellness practices;

''(xvi) personal capacity building;

''(xvii) prenatal, pregnancy, and infant care;

''(xviii) psychological well-being;

''(xix) reproductive health and family planning;

''(xx) safe and adequate water;

''(xxi) healthy work environments;

''(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

''(xxiii) stress control;

''(xxiv) substance abuse;

''(xxv) sanitary facilities;

''(xxvi) sudden infant death syndrome prevention;

''(xxvii) tobacco use cessation and reduction;

''(xxviii) violence prevention; and

''(xxix) such other activities identified by the Service, a tribal health program, or an urban Indian organization to promote achievement of any of the objectives referred to in section 3(2).

''(12) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means—

''(A) any health program administered directly by the Service;

''(B) any tribal health program; and

''(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the 'Buy Indian Act').'';

(10) by inserting after paragraph (14) (as redesignated by paragraph (3)) the following:

''(15) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college' has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

''(16) RESERVATION.—

''(A) IN GENERAL.—The term 'reservation' means a reservation, Pueblo, or colony of any Indian tribe.

''(B) INCLUSIONS.—The term 'reservation' includes—

''(i) former reservations in Oklahoma;

''(ii) Indian allotments; and

''(iii) Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).'';

(11) by striking paragraph (20) (as redesignated by paragraph (3)) and inserting the following:

''(20) SERVICE UNIT.—The term 'Service unit' means an administrative entity of the Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.'';

(12) by inserting after paragraph (21) (as redesignated by paragraph (3)) the following:

''(22) TELEHEALTH.—The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

''(23) TELEMEDICINE.—The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

''(24) TRIBAL COLLEGE OR UNIVERSITY.—The term 'tribal college or university' has the meaning given the term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(25) TRIBAL HEALTH PROGRAM.—The term 'tribal health program' means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''; and

(13) by striking paragraph (26) (as redesignated by paragraph (3)) and inserting the following:

''(26) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).''.

Subtitle A—Indian Health Manpower

SEC. 111. COMMUNITY HEALTH AIDE PROGRAM.

Section 119 of the Indian Health Care Improvement Act (25 U.S.C. 1616*l*) is amended to read as follows:

''SEC. 119. COMMUNITY HEALTH AIDE PROGRAM.

''(a) GENERAL PURPOSES OF PROGRAM.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in the State of Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses those aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near those villages for use by community health aides or community health practitioners.

''(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that those aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education regarding the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objectives specified in section 3(2);

''(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

''(4) develop and maintain a system that identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners;

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to ensure the provision of quality health care, health promotion, and disease prevention services; and

''(7) ensure that—

''(A) pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment; and

''(B) dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, subject to the condition that uncomplicated extractions shall not be considered oral surgery under this section.

''(c) PROGRAM REVIEW.—

''(1) NEUTRAL PANEL.—

''(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

''(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

''(2) STUDY.—

''(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

''(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

''(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

''(i) the ability of the dental health aide therapist services under this section to address the dental care needs of Alaska Natives;

''(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

''(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

''(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska tribal organizations with respect to the adequacy and accuracy of the study.

''(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

''(A) any determination of the neutral panel under paragraph (2)(C); and

''(B) any comments received from Alaska tribal organizations under paragraph (2)(D).

''(d) NATIONALIZATION OF PROGRAM.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

''(2) REQUIREMENT; EXCLUSION.—In establishing a national program under paragraph (1), the Secretary—

''(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b); and

''(B) shall exclude dental health aide therapist services from services covered under the program.''.

SEC. 112. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

''(a) DEMONSTRATION PROGRAMS.—The Secretary, acting through the Service, may fund demonstration programs for Indian health programs to address the chronic shortages of health professionals.

''(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs under subsection (a) shall be—

''(1) to provide direct clinical and practical experience within an Indian health program to health profession students and residents from medical schools;

''(2) to improve the quality of health care for Indians by ensuring access to qualified health professionals;

''(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region; and

''(4) to provide training and support for alternative provider types, such as community health representatives, and community health aides.

''(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board, which may be composed of representatives of tribal governments, Indian health programs, and Indian communities in the areas to be served by the demonstration programs.''.

SEC. 113. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 112) is amended by adding at the end the following:

''SEC. 124. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

''Employees of a tribal health program or urban Indian organization shall be exempt from payment of licensing, registration, and any other fees imposed by a Federal agency to the same extent that officers of the commissioned corps of the Public Health Service and other employees of the Service are exempt from those fees.''.

Subtitle B—Health Services

SEC. 121. INDIAN HEALTH CARE IMPROVEMENT FUND.

Section 201 of the Indian Health Care Improvement Act (25 U.S.C. 1621) is amended to read as follows:

''SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend

funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:

''(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

''(B) Preventive health, including mammography and other cancer screening.

''(C) Dental care.

''(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

''(E) Emergency medical services.

''(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

''(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

''(H) Home health care.

''(I) Community health representatives.

''(J) Maintenance and improvement.

''(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

''(c) ALLOCATION; USE.—

''(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

''(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

''(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objectives set forth in sections 3(1) and 3(2) are not being achieved; and

''(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) AVAILABLE RESOURCES.—The health resources available to an Indian tribe or tribal organization include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

''(e) ELIGIBILITY FOR FUNDS.—Tribal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly recognized or acknowledged Indian tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

''(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service or a tribal health program; and

''(4) an estimate of—

''(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service unit, Indian tribe, or tribal organization;

''(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

''(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

''(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.''.

SEC. 122. CATASTROPHIC HEALTH EMERGENCY FUND.

Section 202 of the Indian Health Care Improvement Act (25 U.S.C. 1621a) is amended to read as follows:

''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

''(1) the amounts deposited under subsection (f); and

''(2) the amounts appropriated to CHEF under this section.

''(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

''(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

''(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) the 2000 level of $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

''(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

''(A) Service Units; or

''(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

''(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

''(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

''(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other law.

''(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.''.

SEC. 123. DIABETES PREVENTION, TREATMENT, AND CONTROL.

Section 204 of the Indian Health Care Improvement Act (25 U.S.C. 1621c) is amended to read as follows:

"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian tribes and tribal organizations, shall determine—

''(1) by Indian tribe and by Service unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

''(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that Service unit.

''(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a tribal health program and may be conducted through appropriate Internet-based health care management programs.

''(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, any such other diabetes programs operated by the Service or tribal health programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian tribes. tribal health programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 and for projects which are added and funded thereafter.

''(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian tribes, and tribal organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

''(A) in each area office, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

''(B) establish in each area office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

''(C) ensure that data collected in each area office regarding diabetes and related complications among Indians are disseminated to all other area offices, subject to applicable patient privacy laws.

''(2) DIABETES CONTROL OFFICERS.—

''(A) IN GENERAL.—The Secretary may establish and maintain in each area office a position of diabetes control officer to coordinate and manage any activity of that area office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

''(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.''.

SEC. 124. OTHER AUTHORITY FOR PROVISION OF SERVICES; SHARED SERVICES FOR LONG-TERM CARE.

(a) OTHER AUTHORITY FOR PROVISION OF SERVICES.—

(1) IN GENERAL.—Section 205 of the Indian Health Care Improvement Act (25 U.S.C. 1621d) is amended to read as follows:

"SEC. 205. OTHER AUTHORITY FOR PROVISION OF SERVICES.

''(a) DEFINITIONS.—In this section:

''(1) ASSISTED LIVING SERVICE.—The term 'assisted living service' means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—

''(A) shall not be required to obtain a license; but

''(B) shall meet all applicable standards for licensure.

''(2) HOME- AND COMMUNITY-BASED SERVICE.—The term 'home- and community-based service' means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

''(3) HOSPICE CARE.—The term 'hospice care' means—

''(A) the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

''(B) such other services as an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of that care.

''(4) LONG-TERM CARE SERVICES.—The term 'long-term care services' has the meaning given the term 'qualified long-term care services' in section 7702B(c) of the Internal Revenue Code of 1986.

''(b) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act for the following services:

''(1) Hospice care.

''(2) Assisted living services.

''(3) Long-term care services.

''(4) Home- and community-based services.

''(c) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care services under this section:

''(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

''(2) Individuals with a mental impairment, such as dementia, Alzheimer's disease, or another disabling mental illness, who may be able to perform activities of daily living under supervision.

''(3) Such other individuals as an applicable tribal health program determines to be appropriate.

''(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may also provide funding under this Act to meet the objectives set forth in section 3 for convenient care services programs pursuant to section 307(c)(2)(A).''.

(2) REPEAL.—Section 821 of the Indian Health Care Improvement Act (25 U.S.C. 1680k) is repealed.

(b) SHARED SERVICES FOR LONG-TERM CARE.—Section 822 of the Indian Health Care Improvement Act (25 U.S.C. 1680*l*) is amended to read as follows:

"SEC. 822. SHARED SERVICES FOR LONG-TERM CARE.

''(a) LONG-TERM CARE.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians.

''(2) INCLUSIONS.—Each agreement under paragraph (1) shall provide for the sharing of staff or other services between the Service or a tribal health program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by the Indian tribe or tribal organization.

''(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian tribe or tribal organization, delegate to the Indian tribe or tribal organization such powers of supervision and control over Service employees as the Secretary determines to be necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal health program be allocated proportionately between the Service and the Indian tribe or tribal organization; and

''(3) may authorize the Indian tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act (42 U.S.C. 1396r).

''(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused, or allow the use of swing beds, for long-term or similar care.''.

SEC. 125. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

Section 206 of the Indian Health Care Improvement Act (25 U.S.C. 1621e) is amended to read as follows:

"SEC. 206. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible

to receive damages, reimbursement, or indemnification for such charges or expenses if—

''(1) such services had been provided by a nongovernmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICABILITY OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

''(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian tribe, or tribal organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

''(e) ENFORCEMENT.—

''(1) IN GENERAL.—The United States, an Indian tribe, or tribal organization may enforce the right of recovery provided under subsection (a) by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian tribe, or tribal organization; or

''(ii) by any representative or heirs of such individual, or

''(B) instituting a separate civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(3) RECOVERY FROM TORTFEASORS.—

''(A) IN GENERAL.—In any case in which an Indian tribe or tribal organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian tribe or tribal organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

''(B) TREATMENT.—The right of an Indian tribe or tribal organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian tribe or tribal organization.

''(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe, tribal organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

''(g) COSTS AND ATTORNEY'S FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorney's fees and costs of litigation.

''(h) NONAPPLICABILITY OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian tribes and tribal organizations with respect to populations served by such Indian tribes and tribal organizations.

''(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian tribes, tribal organizations, and urban Indian organizations.

''(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian tribe, or tribal organization under the provisions of any applicable, Federal, State, or tribal law, including medical lien laws.''.

SEC. 126. CREDITING OF REIMBURSEMENTS.

Section 207 of the Indian Health Care Improvement Act (25 U.S.C. 1621f) is amended to read as follows:

''SEC. 207. CREDITING OF REIMBURSEMENTS.

''(a) USE OF AMOUNTS.—

''(1) RETENTION BY PROGRAM.—Except as provided in sections 202(a)(2) and 813, all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 813, by reason of the provision of health services by the Service, by an Indian tribe or tribal organization, or by an urban Indian organization, shall be credited to the Service, such Indian tribe or tribal organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

''(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

''(A) Titles XVIII, XIX, and XXI of the Social Security Act.

''(B) This Act, including section 813.

''(C) Public Law 87–693.

''(D) Any other provision of law.

''(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).''.

SEC. 127. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

Section 209 of the Indian Health Care Improvement Act (25 U.S.C. 1621h) is amended by striking subsection (d) and inserting the following:

''(d) BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.—

''(1) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian tribes and tribal organizations, shall conduct a study and compile a list of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

''(2) POSITIONS.—The positions referred to in paragraph (1) are—

''(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(i) elementary and secondary education;

''(ii) social services and family and child welfare;

''(iii) law enforcement and judicial services; and

''(iv) alcohol and substance abuse;

''(B) staff positions within the Service; and

''(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes and tribal organizations (without regard to the funding source).

''(3) TRAINING CRITERIA.—

''(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraphs (2)(A) and (2)(B) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian tribe or tribal organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

''(B) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

''(4) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian tribe, tribal organization, or urban Indian organization, or assist the Indian tribe, tribal organization, or urban Indian organization to develop and implement, a program of community education on mental illness. In carrying out this paragraph, the Service shall, upon request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(5) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension

Act of 2009, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of that Act, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this paragraph shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').''.

SEC. 128. CANCER SCREENINGS.

Section 212 of the Indian Health Care Improvement Act (25 U.S.C. 1621k) is amended by inserting ''and other cancer screenings'' before the period at the end.

SEC. 129. PATIENT TRAVEL COSTS.

Section 213 of the Indian Health Care Improvement Act (25 U.S.C. 1621l) is amended to read as follows:

''SEC. 213. PATIENT TRAVEL COSTS.

''(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term 'qualified escort' means—

''(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

''(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

''(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

''(b) PROVISION OF FUNDS.—The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

''(1) emergency air transportation and nonemergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.''.

SEC. 130. EPIDEMIOLOGY CENTERS.

Section 214 of the Indian Health Care Improvement Act (25 U.S.C. 1621m) is amended to read as follows:

''SEC. 214. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT OF CENTERS.—

''(1) IN GENERAL.—The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in subsection (b).

''(2) NEW CENTERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), any new center established after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 may be operated under a grant authorized by subsection (d).

''(B) REQUIREMENT.—Funding provided in a grant described in subparagraph (A) shall not be divisible.

''(3) FUNDS NOT DIVISIBLE.—An epidemiology center established under this subsection shall be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for the center shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian tribes, tribal organizations, and urban Indian organizations in the Service area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and urban Indians;

''(6) provide requested technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out this section.

''(d) GRANTS FOR STUDIES.—

''(1) IN GENERAL.—The Secretary may make grants to Indian tribes, tribal organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

''(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization shall be eligible to receive a grant under this subsection if the intertribal consortium is—

''(A) incorporated for the primary purpose of improving Indian health; and

''(B) representative of the Indian tribes or urban Indian communities residing in the area in which the intertribal consortium is located.

''(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

''(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

''(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

''(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

''(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

''(5) USE OF FUNDS.—A grant provided under paragraph (1) may be used—

''(A) to carry out the functions described in subsection (b);

''(B) to provide information to, and consult with, tribal leaders, urban Indian community leaders, and related health staff regarding health care and health service management issues; and

''(C) in collaboration with Indian tribes, tribal organizations, and urban Indian organizations, to provide to the Service information regarding ways to improve the health status of Indians.

''(e) ACCESS TO INFORMATION.—

''(1) IN GENERAL.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority (as defined in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation)) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).

''(2) ACCESS TO INFORMATION.—The Secretary shall grant to each epidemiology center described in paragraph (1) access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

''(3) REQUIREMENT.—The activities of an epidemiology center described in paragraph (1) shall be for the purposes of research and for preventing and controlling disease, injury, or disability (as those activities are described in section 164.512 of title 45, Code of Federal Regulations (or a successor regulation)), for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).''.

SEC. 131. INDIAN YOUTH GRANT PROGRAM.

Section 216(b)(2) of the Indian Health Care Improvement Act (25 U.S.C. 1621o(b)(2)) is amended by striking ''section 209(m)'' and inserting ''section 708(c)''.

SEC. 132. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

Section 217 of the Indian Health Care Improvement Act (25 U.S.C. 1621p) is amended to read as follows:

''SEC. 217. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian health programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

''(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

''(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

''(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

''(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

''(7) to the maximum extent feasible, employs qualified Indians in the program.

''(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

''(1) in an Indian health program;

''(2) in a program assisted under title V; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,700,000 for fiscal year 2010 and each fiscal year thereafter.''.

SEC. 133. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

Section 218 of the Indian Health Care Improvement Act (25 U.S.C. 1621q) is amended to read as follows:

''SEC. 218. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian tribes and tribal organizations for the following:

''(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. pylori.

''(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

''(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

''(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

''(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

''(c) COORDINATION WITH HEALTH AGENCIES.—Indian tribes and tribal organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

''(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.''.

SEC. 134. METHODS TO INCREASE CLINICIAN RECRUITMENT AND RETENTION ISSUES.

(a) LICENSING.—Section 221 of the Indian Health Care Improvement Act (25 U.S.C. 1621t) is amended to read as follows:

''SEC. 221. LICENSING.

''Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''.

(b) TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.—Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) (as amended by section 113) is amended by adding at the end the following:

''SEC. 125. TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.

''A scholarship provided to an individual pursuant to this title shall be considered to be a qualified scholarship for purposes of section 117 of the Internal Revenue Code of 1986.''.

(c) CONTINUING EDUCATION ALLOWANCES.—Section 106 of the Indian Health Care Improvement Act (25 U.S.C. 1615) is amended to read as follows:

''SEC. 106. CONTINUING EDUCATION ALLOWANCES.

''In order to encourage scholarship and stipend recipients under sections 104, 105, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian health program and to provide services in the rural and remote areas in which a significant portion of Indians reside, the Secretary, acting through the Service, may—

''(1) provide programs or allowances to transition into an Indian health program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, and 115; and

''(2) provide programs or allowances to health professionals employed in an Indian health program to enable those professionals, for a period of time each year prescribed by regulation of the Secretary, to take leave of the duty stations of the professionals for professional consultation, management, leadership, and refresher training courses.''.

SEC. 135. LIABILITY FOR PAYMENT.

Section 222 of the Indian Health Care Improvement Act (25 U.S.C. 1621u) is amended to read as follows:

''SEC. 222. LIABILITY FOR PAYMENT.

''(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

''(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the services.''.

SEC. 136. OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

Section 223 of the Indian Health Care Improvement Act (25 U.S.C. 1621v) is amended—

(1) by striking the section designation and heading and all that follows through ''oversee efforts of the Service to'' and inserting the following:

''SEC. 223. OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

''(a) OFFICE OF INDIAN MEN'S HEALTH.—

''(1) ESTABLISHMENT.—The Secretary may establish within the Service an office, to be known as the 'Office of Indian Men's Health'.

''(2) DIRECTOR.—

''(A) IN GENERAL.—The Office of Indian Men's Health shall be headed by a director, to be appointed by the Secretary.

''(B) DUTIES.—The director shall coordinate and promote the health status of Indian men in the United States.

''(3) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, shall submit to Congress a report describing—

''(A) any activity carried out by the director as of the date on which the report is prepared; and

''(B) any finding of the director with respect to the health of Indian men.

''(b) OFFICE OF INDIAN WOMEN'S HEALTH.—The Secretary, acting through the Service, shall establish an office, to be known as the 'Office of Indian Women's Health', to''; and

(2) in subsection (b) (as so redesignated) by inserting ''(including urban Indian women)'' before ''of all ages''.

SEC. 137. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621 et seq.) is amended by adding at the end the following:

''SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

''(a) SUBMISSION OF REPORT.—As soon as practicable after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General of the United States shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives, and make available to each Indian tribe, a report describing the results of the study of the Comptroller General regarding the funding of the contract health service program (including historic funding levels and a recommendation of the funding level needed for the program) and the administration of the contract health service program (including the distribution of funds pursuant to the program), as requested by Congress in March 2009, or pursuant to section 830.

''(b) CONSULTATION WITH TRIBES.—On receipt of the report under subsection (a), the Secretary shall consult with Indian tribes regarding the contract health service program, including the distribution of funds pursuant to the program—

''(1) to determine whether the current distribution formula would require modification if the contract health service program were funded at the level recommended by the Comptroller General;

''(2) to identify any inequities in the current distribution formula under the current funding level or inequitable results for any Indian tribe under the funding level recommended by the Comptroller General;

''(3) to identify any areas of program administration that may result in the inefficient or ineffective management of the program; and

''(4) to identify any other issues and recommendations to improve the administration of the contract health services program and correct any unfair results or funding disparities identified under paragraph (2).

''(c) SUBSEQUENT ACTION BY SECRETARY.—If, after consultation with Indian tribes under subsection (b), the Secretary determines that any issue described in subsection (b)(2) exists, the Secretary may initiate procedures under subchapter III of chapter 5 of

title 5, United States Code, to negotiate or promulgate regulations to establish a disbursement formula for the contract health service program funding.''.

Subtitle C—Health Facilities

SEC. 141. HEALTH CARE FACILITY PRIORITY SYSTEM.

Section 301 of the Indian Health Care Improvement Act (25 U.S.C. 1631) is amended—

(1) by redesignating subsection (d) as subsection (h); and

(2) by striking subsection (c) and inserting the following:

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) PRIORITY SYSTEM.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

''(i) shall be developed in consultation with Indian tribes and tribal organizations;

''(ii) shall give Indian tribes' needs the highest priority;

''(iii)(I) may include the lists required in paragraph (2)(B)(ii); and

''(II) shall include the methodology required in paragraph (2)(B)(v); and

''(III) may include such health care facilities, and such renovation or expansion needs of any health care facility, as the Service may identify; and

''(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian tribes, and tribal organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

''(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

''(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

''(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall not be affected by any change in the construction priority system taking place after that date if the project—

''(i) was identified in the fiscal year 2008 Service budget justification as—

''(I) 1 of the 10 top-priority inpatient projects;

''(II) 1 of the 10 top-priority outpatient projects;

''(III) 1 of the 10 top-priority staff quarters developments; or

''(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

''(ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

''(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

''(I) on the initiative of the Secretary; or

''(II) pursuant to a request of an Indian tribe or tribal organization.

''(2) REPORT; CONTENTS.—

''(A) INITIAL COMPREHENSIVE REPORT.—

''(i) DEFINITIONS.—In this subparagraph:

''(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term 'Facilities Appropriation Advisory Board' means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director—

''(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

''(bb) to address other facilities issues.

''(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term 'Facilities Needs Assessment Workgroup' means the workgroup established at the discretion of the Director—

''(aa) to review the health care facilities construction priority system; and

''(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

''(ii) INITIAL REPORT.—

''(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian tribes, and tribal organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

''(II) INCLUSIONS.—The initial report shall include—

''(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

''(bb) such other information as the Secretary determines to be appropriate.

''(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

''(I) update the report under clause (ii) not less frequently that once every 5 years; and

''(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

''(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

''(i) A description of the health care facility priority system of the Service established under paragraph (1).

''(ii) Health care facilities lists, which may include—

''(I) the 10 top-priority inpatient health care facilities;

''(II) the 10 top-priority outpatient health care facilities;

''(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment); and

''(IV) the 10 top-priority staff quarters developments associated with health care facilities.

''(iii) The justification for such order of priority.

''(iv) The projected cost of such projects.

''(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing the report required under paragraph (2), the Secretary shall—

''(A) consult with and obtain information on all health care facilities needs from Indian tribes and tribal organizations; and

''(B) review the total unmet needs of all Indian tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

''(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

''(1) IN GENERAL.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

''(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

''(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

''(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

''(A) the Committees on Indian Affairs and Appropriations of the Senate;

''(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

''(C) the Secretary.

''(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f) or sections 504 and 505 of that Act (25 U.S.C. 458aaa–3, 458aaa–4).

''(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include—

''(1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service areas;

''(2) approaches provided for in other provisions of this title; and

''(3) other approaches, as the Secretary determines to be appropriate.''.

SEC. 142. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

Section 307 of the Indian Health Care Improvement Act (25 U.S.C. 1637) is amended to read as follows:

''SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

''(a) PURPOSE AND GENERAL AUTHORITY.—

''(1) PURPOSE.—The purpose of this section is to encourage the establishment of demonstration projects that meet the applicable criteria of this section to be carried out by the Secretary, acting through the Service, or Indian tribes or tribal organizations acting pursuant to contracts or compacts under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

''(A) to test alternative means of delivering health care and services to Indians through facilities; or

''(B) to use alternative or innovative methods or models of delivering health care services to Indians (including primary care services, contract health services, or any other program or service authorized by this Act) through convenient care services (as defined in subsection (c)), community health centers, or cooperative agreements or arrangements with other health care providers that share or coordinate the use of facilities, funding, or other resources, or otherwise coordinate or improve the coordination of activities of the Service, Indian tribes, or tribal organizations, with those of the other health care providers.

''(2) AUTHORITY.—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations to carry out, health care delivery demonstration projects that—

''(A) test alternative means of delivering health care and services to Indians through facilities; or

''(B) otherwise carry out the purposes of this section.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section—

''(1) may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services; and

''(2) is authorized—

''(A) to waive any leasing prohibition;

''(B) to permit use and carryover of funds appropriated for the provision of health care services under this Act (including for the purchase of health benefits coverage, as authorized by section 402(a));

''(C) to permit the use of other available funds, including other Federal funds, funds from third-party collections in accordance with sections 206, 207, and 401, and non-Federal funds contributed by State or local governmental agencies or facilities or private health care providers pursuant to cooperative or other agreements with the Service, 1 or more Indian tribes, or tribal organizations;

''(D) to permit the use of funds or property donated or otherwise provided from any source for project purposes;

''(E) to provide for the reversion of donated real or personal property to the donor; and

''(F) to permit the use of Service funds to match other funds, including Federal funds.

''(c) HEALTH CARE DEMONSTRATION PROJECTS.—

''(1) DEFINITION OF CONVENIENT CARE SERVICE.—In this subsection, the term 'convenient care service' means any primary health care service, such as urgent care services, nonemergent care services, prevention services and screenings, and any service authorized by section 203 or 205(d), that is offered—

''(A) at an alternative setting; or

''(B) during hours other than regular working hours.

''(2) GENERAL PROJECTS.—

''(A) CRITERIA.—The Secretary may approve under this section demonstration projects that meet the following criteria:

''(i) There is a need for a new facility or program, such as a program for convenient care services, or an improvement in, increased efficiency at, or reorientation of an existing facility or program.

''(ii) A significant number of Indians, including Indians with low health status, will be served by the project.

''(iii) The project has the potential to deliver services in an efficient and effective manner.

''(iv) The project is economically viable.

''(v) For projects carried out by an Indian tribe or tribal organization, the Indian tribe or tribal organization has the administrative and financial capability to administer the project.

''(vi) The project is integrated with providers of related health or social services (including State and local health care agencies or other health care providers) and is coordinated with, and avoids duplication of, existing services in order to expand the availability of services.

''(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service units:

''(i) Cass Lake, Minnesota.

''(ii) Mescalero, New Mexico.

''(iii) Owyhee and Elko, Nevada.

''(iv) Schurz, Nevada.

''(v) Ft. Yuma, California.

''(3) INNOVATIVE HEALTH SERVICES DELIVERY DEMONSTRATION PROJECT.—

''(A) APPLICATION OR REQUEST.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization within a Service area, the Secretary shall take into consideration alternative or innovated methods to deliver health care services within the Service area (or a portion of, or facility within, the Service area) as described in the application or request, including medical, dental, pharmaceutical, nursing, clinical laboratory, contract health services, convenient care services, community health centers, or any other health care services delivery models designed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under this Act.

''(B) APPROVAL.—In addition to projects described in paragraph (2), in any fiscal year, the Secretary is authorized under this paragraph to approve not more than 10 applications for health care delivery demonstration projects that meet the criteria described in subparagraph (C).

''(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

''(i) The criteria set forth in paragraph (2)(A).

''(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at those facilities or other factors.

''(iii) The project—

''(I) expands the availability of services; or

''(II) reduces—

''(aa) the burden on Contract Health Services; or

''(bb) the need for emergency room visits.

''(d) TECHNICAL ASSISTANCE.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization, the Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section, including information regarding the Service unit budget and available funding for carrying out the proposed demonstration project.

''(e) SERVICE TO INELIGIBLE PERSONS.—Subject to section 813, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service, and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 813, may be included, subject to the terms of that section, in any demonstration project approved pursuant to this section.

''(f) EQUITABLE TREATMENT.—For purposes of subsection (c), the Secretary, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities that are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.''.

SEC. 143. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

Title III of the Indian Health Care Improvement Act (as amended by section 101(b)) is amended by inserting after section 308 (25 U.S.C. 1638) the following:

''SEC. 309. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a tribal health program that operates a hospital or other health facility and the federally owned quarters associated with such a facility pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may establish the rental rates charged to the occupants of those quarters, on providing notice to the Secretary.

''(2) OBJECTIVES.—In establishing rental rates under this subsection, a tribal health program shall attempt—

''(A) to base the rental rates on the reasonable value of the quarters to the occupants of the quarters; and

''(B) to generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and at the discretion of the tribal health program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—A federally owned quarters the rental rates for which are established by a tribal health program under this subsection shall remain eligible to receive improvement and repair funds to the same extent that all federally owned quarters used to house personnel in programs of the Service are eligible to receive those funds.

''(4) NOTICE OF RATE CHANGE.—A tribal health program that establishes a rental rate under this subsection shall provide occupants of the federally owned quarters a notice of any change in the rental rate by not later than the date that is 60 days notice before the effective date of the change.

''(5) RATES IN ALASKA.—A rental rate established by a tribal health program under this section for a federally owned quarters in the State of Alaska may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

''(b) DIRECT COLLECTION OF RENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a tribal health program may collect rent directly from Federal employees who occupy federally owned quarters if the tribal health program submits to the Secretary and the employees a notice of the election of the tribal health program to collect rents directly from the employees.

''(2) ACTION BY EMPLOYEES.—On receipt of a notice described in paragraph (1)—

''(A) the affected Federal employees shall pay rent for occupancy of a federally owned quarters directly to the applicable tribal health program; and

''(B) the Secretary shall not have the authority to collect rent from the employees through payroll deduction or otherwise.

''(3) USE OF PAYMENTS.—The rent payments under this subsection—

''(A) shall be retained by the applicable tribal health program in a separate account, which shall be used by the tribal health program for the maintenance (including capital repairs and replacement) and operation of the quarters, as the tribal health program determines to be appropriate; and

''(B) shall not be made payable to, or otherwise be deposited with, the United States.

''(4) RETROCESSION OF AUTHORITY.—If a tribal health program that elected to collect rent directly under paragraph (1) requests retrocession of the authority of the tribal health program to collect that rent, the retrocession shall take effect on the earlier of—

''(A) the first day of the month that begins not less than 180 days after the tribal health program submits the request; and

''(B) such other date as may be mutually agreed on by the Secretary and the tribal health program.''.

SEC. 144. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at the end the following:

''SEC. 311. OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

''(a) AUTHORIZATION.—

''(1) AUTHORITY TO TRANSFER FUNDS.—The head of any Federal agency to which funds, equipment, or other supplies are made available for the planning, design, construction, or operation of a health care or sanitation facility may transfer the funds, equipment, or supplies to the Secretary for the planning, design, construction, or operation of a health care or sanitation facility to achieve—

''(A) the purposes of this Act; and

''(B) the purposes for which the funds, equipment, or supplies were made available to the Federal agency.

''(2) AUTHORITY TO ACCEPT FUNDS.—The Secretary may—

''(A) accept from any source, including Federal and State agencies, funds, equipment, or supplies that are available for the construction or operation of health care or sanitation facilities; and

''(B) use those funds, equipment, and supplies to plan, design, construct, and operate health care or sanitation facilities for Indians, including pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(3) EFFECT OF RECEIPT.—Receipt of funds by the Secretary under this subsection shall not affect any priority established under section 301.

''(b) INTERAGENCY AGREEMENTS.—The Secretary may enter into interagency agreements with Federal or State agencies and other entities, and accept funds, equipment, or other supplies from those entities, to provide for the planning, design, construction, and operation of health care or sanitation facilities to be administered by Indian health programs to achieve—

''(1) the purposes of this Act; and

''(2) the purposes for which the funds were appropriated or otherwise provided.

''(c) ESTABLISHMENT OF STANDARDS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians under this Act.

''(2) OTHER REGULATIONS.—Notwithstanding any other provision of law, any other applicable regulations of the Department shall apply in carrying out projects using funds transferred under this section.

''(d) DEFINITION OF SANITATION FACILITY.—In this section, the term 'sanitation facility' means a safe and adequate water supply system, sanitary sewage disposal system, or sanitary solid waste system (including all related equipment and support infrastructure).''.

SEC. 145. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) (as amended by section 144) is amended by adding at the end the following:

''SEC. 312. INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

''(a) DEFINITION OF MODULAR COMPONENT HEALTH CARE FACILITY.—In this section, the term 'modular component health care facility' means a health care facility that is constructed—

''(1) off-site using prefabricated component units for subsequent transport to the destination location; and

''(2) represents a more economical method for provision of health care facility than a traditionally constructed health care building.

''(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall award no less than 3 grants for purchase, installation and maintenance of modular component health care facilities in Indian communities for provision of health care services.

''(c) SELECTION OF LOCATIONS.—

''(1) PETITIONS.—

''(A) SOLICITATION.—The Secretary shall solicit from Indian tribes petitions for location of the modular component health care facilities in the Service areas of the petitioning Indian tribes.

''(B) PETITION.—To be eligible to receive a grant under this section, an Indian tribe or tribal organization must submit to the Secretary a petition to construct a modular component health care facility in the Indian community of the Indian tribe, at such time, in such manner, and containing such information as the Secretary may require.

''(2) SELECTION.—In selecting the location of each modular component health care facility to be provided under the demonstration program, the Secretary shall give priority to projects already on the Indian Health Service facilities construction priority list and petitions which demonstrate that erection of a modular component health facility—

''(A) is more economical than construction of a traditionally constructed health care facility;

''(B) can be constructed and erected on the selected location in less time than traditional construction; and

''(C) can adequately house the health care services needed by the Indian population to be served.

''(3) EFFECT OF SELECTION.—A modular component health care facility project selected for participation in the demonstration program shall not be eligible for entry on the facilities construction priorities list entitled 'IHS Health Care Facilities FY 2011 Planned Construction Budget' and dated May 7, 2009 (or any successor list).

''(d) ELIGIBILITY.—

''(1) IN GENERAL.—An Indian tribe may submit a petition under subsection (c)(1)(B) regardless of whether the Indian tribe is a party to any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

''(2) ADMINISTRATION.—At the election of an Indian tribe or tribal organization selected for participation in the demonstration program, the funds provided for the project shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

''(e) REPORTS.—Not later than 1 year after the date on which funds are made available for the demonstration program and annually thereafter, the Secretary shall submit to Congress a report describing—

''(1) each activity carried out under the demonstration program, including an evaluation of the success of the activity; and

''(2) the potential benefits of increased use of modular component health care facilities in other Indian communities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000,000 to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be necessary to carry out the program in subsequent fiscal years.''.

SEC. 146. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) (as amended by section 145) is amended by adding at the end the following:

''SEC. 313. MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE TRIBAL CONSORTIUM.—The term 'eligible tribal consortium' means a consortium composed of 2 or more Service units between which a mobile health station can be transported by road in up to 8 hours. A Service unit operated by the Service or by an Indian tribe or tribal organization shall be equally eligible for participation in such consortium.

''(2) MOBILE HEALTH STATION.—The term 'mobile health station' means a health care unit that—

''(A) is constructed, maintained, and capable of being transported within a semi-trailer truck or similar vehicle;

''(B) is equipped for the provision of 1 or more specialty health care services; and

''(C) can be equipped to be docked to a stationary health care facility when appropriate.

''(3) SPECIALTY HEALTH CARE SERVICE.—

''(A) IN GENERAL.—The term 'specialty health care service' means a health care service which requires the services of a health care professional with specialized knowledge or experience.

''(B) INCLUSIONS.—The term 'specialty health care service' includes any service relating to—

''(i) dialysis;

''(ii) surgery;

''(iii) mammography;

''(iv) dentistry; or

''(v) any other specialty health care service.

''(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall provide at least 3 mobile health station projects.

''(c) PETITION.—To be eligible to receive a mobile health station under the demonstration program, an eligible tribal consortium shall submit to the Secretary, a petition at such time, in such manner, and containing—

''(1) a description of the Indian population to be served;

''(2) a description of the specialty service or services for which the mobile health station is requested and the extent to which such service or services are currently available to the Indian population to be served; and

''(3) such other information as the Secretary may require.

''(d) USE OF FUNDS.—The Secretary shall use amounts made available to carry out the demonstration program under this section—

''(1)(A) to establish, purchase, lease, or maintain mobile health stations for the eligible tribal consortia selected for projects; and

''(B) to provide, through the mobile health station, such specialty health care services as the affected eligible tribal consortium determines to be necessary for the Indian population served;

''(2) to employ an existing mobile health station (regardless of whether the mobile health station is owned or rented and operated by the Service) to provide specialty health care services to an eligible tribal consortium; and

''(3) to establish, purchase, or maintain docking equipment for a mobile health station, including the establishment or maintenance of such equipment at a modular component health care facility (as defined in section 312(a)), if applicable.

''(e) REPORTS.—Not later than 1 year after the date on which the demonstration program is established under subsection (b) and annually thereafter, the Secretary, acting through the Service, shall submit to Congress a report describing—

''(1) each activity carried out under the demonstration program including an evaluation of the success of the activity; and

''(2) the potential benefits of increased use of mobile health stations to provide specialty health care services for Indian communities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $5,000,000 per year to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be needed to carry out the program in subsequent fiscal years.''.

Subtitle D—Access to Health Services

SEC. 151. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

Section 401 of the Indian Health Care Improvement Act (25 U.S.C. 1641) is amended to read as follows:

''SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

''(a) DISREGARD OF MEDICARE, MEDICAID, AND CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian health program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XI of the Social Security Act in preference to an Indian without such coverage.

''(c) USE OF FUNDS.—

''(1) SPECIAL FUND.—

''(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service unit makes collections, are entitled by reason of a provision of either such title.

''(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 201(c)) of such Indian tribes, including the provision of services pursuant to section 205.

''(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a tribal health program upon the election of such program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such program during the period of such election.

''(d) DIRECT BILLING.—

''(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a tribal health program may elect to directly bill for, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any portion of a contract health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 3 of this Act.

''(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian health program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

''(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any tribal health program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such program receives such reimbursements or payments.

''(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

''(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under title XIX or XXI of the Social Security Act.

''(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data regarding patients served by the Service (and by tribal health programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A tribal health program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a tribal health program or in the direct billing program established under this subsection if the Secretary determines that the program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a tribal health program with notice of a determination that the program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the program's participation in the direct billing program established under this subsection.

''(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.''.

SEC. 152. PURCHASING HEALTH CARE COVERAGE.

Section 402 of the Indian Health Care Improvement Act (25 U.S.C. 1642) is amended to read as follows:

''SEC. 402. PURCHASING HEALTH CARE COVERAGE.

''(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 404) to Indian tribes, tribal organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian tribes, tribal organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage (including coverage for a service, or service within a contract health service delivery area, or any portion of a contract health service delivery area that would otherwise be provided as a contract health service) for such beneficiaries in any manner, including through—

''(1) a tribally owned and operated health care plan;

''(2) a State or locally authorized or licensed health care plan;

''(3) a health insurance provider or managed care organization;

''(4) a self-insured plan; or

''(5) a high deductible or health savings account plan.

''(b) FINANCIAL NEED.—The purchase of coverage under subsection (a) by an Indian tribe, tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries (as determined by the 1 or more Indian tribes being served based on a schedule of income levels developed or implemented by such 1 ore more Indian tribes).

''(c) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).''.

SEC. 153. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

Section 404 of the Indian Health Care Improvement Act (25 U.S.C. 1644) is amended to read as follows:

''SEC. 404. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian tribes and tribal organizations to assist such tribes and tribal organizations in establishing and administering programs on or near reservations and trust lands, including programs to provide outreach and enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program, to assist individual Indians—

''(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

''(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian tribe or tribes or tribal organizations being served based on a schedule of income levels developed or implemented by such tribe, tribes, or tribal organizations).

''(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include requirements that the Indian tribe or tribal organization successfully undertake—

''(1) to determine the population of Indians eligible for the benefits described in subsection (a);

''(2) to educate Indians with respect to the benefits available under the respective programs;

''(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

''(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

''(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to urban Indian organizations with respect to populations served by such organizations in the same manner they apply to grants and contracts with Indian tribes and tribal organizations with respect to programs on or near reservations.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

''(A) consistent with the requirements imposed by the Secretary under subsection (b);

''(B) appropriate to urban Indian organizations and urban Indians; and

''(C) necessary to effect the purposes of this section.

''(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall develop and disseminate best practices that will serve to facilitate cooperation with, and agreements between, States and the Service, Indian tribes, tribal organizations, or urban Indian organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI of the Social Security Act.

''(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements of the Secretary, acting through the Service, for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

''(f) DEFINITION OF PREMIUMS AND COST SHARING.—In this section:

''(1) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

''(2) COST SHARING.—The term 'cost sharing' includes any deduction, deductible, copayment, coinsurance, or similar charge.''.

SEC. 154. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) is amended to read as follows:

''SEC. 405. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian tribes, and tribal organizations and the Department of Veterans Affairs and the Department of Defense.

''(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian tribes which will be significantly affected by the arrangement.

''(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

''(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

''(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.''.

SEC. 155. ELIGIBLE INDIAN VETERAN SERVICES.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

''(a) FINDINGS; PURPOSE.—

''(1) FINDINGS.—Congress finds that—

''(A) collaborations between the Secretary and the Secretary of Veterans Affairs regarding the treatment of Indian veterans at facilities of the Service should be encouraged to the maximum extent practicable; and

''(B) increased enrollment for services of the Department of Veterans Affairs by veterans who are members of Indian tribes should be encouraged to the maximum extent practicable.

''(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Service).

''(b) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIAN VETERAN.—The term 'eligible Indian veteran' means an Indian or Alaska Native veteran who receives any medical service that is—

''(A) authorized under the laws administered by the Secretary of Veterans Affairs; and

''(B) administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) pursuant to a local memorandum of understanding.

''(2) LOCAL MEMORANDUM OF UNDERSTANDING.—The term 'local memorandum of understanding' means a memorandum of understanding between the Secretary (or a designee, including the director of any area office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled 'Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service' and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

''(c) ELIGIBLE INDIAN VETERANS EXPENSES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall

provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

''(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

''(d) TRIBAL APPROVAL OF MEMORANDA.—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

''(e) FUNDING.—

''(1) TREATMENT.—Expenses incurred by the Secretary in carrying out subsection (c)(1) shall not be considered to be Contract Health Service expenses.

''(2) USE OF FUNDS.—Of funds made available to the Secretary in appropriations Acts for the Service (excluding funds made available for facilities, Contract Health Services, or contract support costs), the Secretary shall use such sums as are necessary to carry out this section.''.

SEC. 156. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 155) is amended by adding at the end the following:

''SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

''(a) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

''(2) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

''(b) APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—

''(1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

''(2) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

''(3) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

''(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian tribe, tribal organization, or urban Indian organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).''.

SEC. 157. ACCESS TO FEDERAL INSURANCE.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 156) is amended by adding at the end the following:

''SEC. 409. ACCESS TO FEDERAL INSURANCE.

''Notwithstanding the provisions of title 5, United States Code, Executive order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights, and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.''.

SEC. 158. GENERAL EXCEPTIONS.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 157) is amended by adding at the end the following:

''SEC. 410. GENERAL EXCEPTIONS.

''The requirements of this title shall not apply to any excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91).''.

SEC. 159. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et seq.) (as amended by section 158) is amended by adding at the end the following:

''SEC. 411. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

''(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

''(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

''(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

''(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

''(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

''(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

''(c) REPORT.—Not later then 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

''(1) the results of the study under this section;

''(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

''(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

''(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.''.

Subtitle E—Health Services for Urban Indians

SEC. 161. FACILITIES RENOVATION.

Section 509 of the Indian Health Care Improvement Act (25 U.S.C. 1659) is amended by inserting ''or construction or expansion of facilities'' after ''renovations to facilities''.

SEC. 162. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

Section 512 of the Indian Health Care Improvement Act (25 U.S.C. 1660b) is amended to read as follows:

''SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service units and operating units in the allocation of resources and coordination of care; and

''(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).''.

SEC. 163. REQUIREMENT TO CONFER WITH URBAN INDIAN ORGANIZATIONS.

(a) CONFERRING WITH URBAN INDIAN ORGANIZATIONS.—Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

"SEC. 514. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

''(a) DEFINITION OF CONFER.—In this section, the term 'confer' means to engage in an open and free exchange of information and opinions that—

''(1) leads to mutual understanding and comprehension; and

''(2) emphasizes trust, respect, and shared responsibility.

''(b) REQUIREMENT.—The Secretary shall ensure that the Service confers, to the maximum extent practicable, with urban Indian organizations in carrying out this Act.''.

(b) CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.—Section 502 of the Indian Health Care Improvement Act (25 U.S.C. 1652) is amended to read as follows:

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist the urban Indian organizations in the establishment and administration, within urban centers, of programs that meet the requirements of this title.

''(b) CONDITIONS.—Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.''.

SEC. 164. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 163(a)) is amended by adding at the end the following:

"SEC. 515. EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

''Notwithstanding any other provision of this Act, the Secretary, acting through the Service, is authorized to establish programs, including programs for awarding grants, for urban Indian organizations that are identical to any programs established pursuant to sections 218, 702, and 708(g).''.

SEC. 165. COMMUNITY HEALTH REPRESENTATIVES.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 164) is amended by adding at the end the following:

"SEC. 516. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representative Program under section 107 in the provision of health care, health promotion, and disease prevention services to urban Indians.''.

SEC. 166. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY; HEALTH INFORMATION TECHNOLOGY.

Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) (as amended by section 165) is amended by adding at the end the following:

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out the contract or grant, to use, in accordance with such terms and conditions for use and maintenance as are agreed on by the Secretary and the urban Indian organizations—

''(1) any existing facility under the jurisdiction of the Secretary;

''(2) all equipment contained in or pertaining to such an existing facility; and

''(3) any other personal property of the Federal Government under the jurisdiction of the Secretary.

''(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for the purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus personal or real property of the Federal Government for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for purposes of the contract or grant.

''(d) PRIORITY.—If the Secretary receives from an urban Indian organization or an Indian tribe or tribal organization a request for a specific item of personal or real property described in subsection (b) or (c), the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization, if the Secretary receives the request from the Indian tribe or tribal organization before the earlier of—

''(1) the date on which the Secretary transfers title to the property to the urban Indian organization; and

''(2) the date on which the Secretary transfers the property physically to the urban Indian organization.

''(e) EXECUTIVE AGENCY STATUS.—For purposes of section 501(a) of title 40, United States Code, an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be considered to be an Executive agency in carrying out the contract or grant.

"SEC. 518. HEALTH INFORMATION TECHNOLOGY.

''The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)), telemedicine services development, and related infrastructure.''.

Subtitle F—Organizational Improvements

SEC. 171. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended to read as follows:

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) DIRECTOR.—The Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2008, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

''(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall serve as Director.

''(4) ADVOCACY AND CONSULTATION.—The position of Director is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

''(A) facilitate advocacy for the development of appropriate Indian health policy; and

''(B) promote consultation on matters relating to Indian health.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) DUTIES.—The Director shall—

''(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, carried out by or under the direction of the individual serving as Director of the Service on that day;

''(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians, including by ensuring that all agency directors, managers, and chief executive officers have appropriate and adequate training, experience, skill levels, knowledge, abilities, and education (including continuing training requirements) to competently fulfill the duties of the positions and the mission of the Service;

''(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

''(4) administer all scholarship and loan functions carried out under title I;

''(5) directly advise the Secretary concerning the development of all policy- and budget-related matters affecting Indian health;

''(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

''(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

''(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

''(9) coordinate the activities of the Department concerning matters of Indian health; and

''(10) perform such other functions as the Secretary may designate.

''(d) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Director, shall have the authority—

''(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).''.

SEC. 172. OFFICE OF DIRECT SERVICE TRIBES.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) (as amended by section 101(b)) is amended by adding at the end the following:

''SEC. 603. OFFICE OF DIRECT SERVICE TRIBES.

''(a) ESTABLISHMENT.—There is established within the Service an office, to be known as the 'Office of Direct Service Tribes'.

''(b) TREATMENT.—The Office of Direct Service Tribes shall be located in the Office of the Director.

''(c) DUTIES.—The Office of Direct Service Tribes shall be responsible for—

''(1) providing Service-wide leadership, guidance and support for direct service tribes to include strategic planning and program evaluation;

''(2) ensuring maximum flexibility to tribal health and related support systems for Indian beneficiaries;

''(3) serving as the focal point for consultation and participation between direct service tribes and organizations and the Service in the development of Service policy;

''(4) holding no less than biannual consultations with direct service tribes in appropriate locations to gather information and aid in the development of health policy; and

''(5) directing a national program and providing leadership and advocacy in the development of health policy, program management, budget formulation, resource allocation, and delegation support for direct service tribes.''.

SEC. 173. NEVADA AREA OFFICE.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) (as amended by section 172) is amended by adding at the end the following:

''SEC. 604. NEVADA AREA OFFICE.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, in a manner consistent with the tribal consultation policy of the Service, the Secretary shall submit to Congress a plan describing the manner and schedule by which an area office, separate and distinct from the Phoenix Area Office of the Service, can be established in the State of Nevada.

''(b) FAILURE TO SUBMIT PLAN.—

''(1) DEFINITION OF OPERATIONS FUNDS.—In this subsection, the term 'operations funds' means only the funds used for—

''(A) the administration of services, including functional expenses such as overtime, personnel salaries, and associated benefits; or

''(B) related tasks that directly affect the operations described in subparagraph (A).

''(2) WITHHOLDING OF FUNDS.—If the Secretary fails to submit a plan in accordance with subsection (a), the Secretary shall withhold the operations funds reserved for the Office of the Director, subject to the condition that the withholding shall not adversely impact the capacity of the Service to deliver health care services.

''(3) RESTORATION.—The operations funds withheld pursuant to paragraph (2) may be restored, at the discretion of the Secretary, to the Office of the Director on achievement by that Office of compliance with this section.''.

Subtitle G—Behavioral Health Programs

SEC. 181. BEHAVIORAL HEALTH PROGRAMS.

Title VII of the Indian Health Care Improvement Act (25 U.S.C. 1665 et seq.) is amended to read as follows:

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''Subtitle A—General Programs

''SEC. 701. DEFINITIONS.

''In this subtitle:

''(1) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS; ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system abnormalities, which may range from minor intellectual deficits and developmental delays to mental retardation. ARND children may have behavioral problems, learning disabilities, problems with executive functioning, and attention disorders. The neurological defects of ARND may be as severe as FAS, but facial anomalies and other physical characteristics are not present in ARND, thus making diagnosis difficult.

''(2) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

''(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

''(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

''(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

''(A) IN GENERAL.—The term 'fetal alcohol spectrum disorders' includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

''(B) INCLUSIONS.—The term 'fetal alcohol spectrum disorders' may include—

''(i) fetal alcohol syndrome (FAS);

''(ii) partial fetal alcohol syndrome (partial FAS);

''(iii) alcohol-related birth defects (ARBD); and

''(iv) alcohol-related neurodevelopmental disorders (ARND).

''(6) FAS OR FETAL ALCOHOL SYNDROME.—The term 'FAS' or 'fetal alcohol syndrome' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

''(A) Central nervous system involvement, such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurological abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following:

''(i) Microophthalmia.

''(ii) Short palpebral fissures.

''(iii) Poorly developed philtrum.

''(iv) Thin upper lip.

''(v) Flat nasal bridge.

''(vi) Short upturned nose.

''(C) Prenatal or postnatal growth delay.

''(7) REHABILITATION.—The term 'rehabilitation' means medical and health care services that—

''(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law;

''(B) are furnished in a facility, home, or other setting in accordance with applicable standards; and

''(C) have as their purpose any of the following:

''(i) The maximum attainment of physical, mental, and developmental functioning.

''(ii) Averting deterioration in physical or mental functional status.

''(iii) The maintenance of physical or mental health functional status.

''(8) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''SEC. 702. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—The purposes of this section are as follows:

''(1) To authorize and direct the Secretary, acting through the Service, Indian tribes, and tribal organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

''(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

''(3) To assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

''(4) To provide authority and opportunities for Indian tribes and tribal organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

''(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

''(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) PLANS.—

''(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, and urban Indian organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

''(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

''(ii) an estimate of the financial and human cost attributable to such illness or behavior.

''(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

''(C) An estimate of the additional funding needed by the Service, Indian tribes, tribal organizations, and urban Indian organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian tribes, tribal organizations, urban Indian organizations, and Service areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian tribe, tribal organization, urban Indian organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

''(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

''(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

''(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient/day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

''(G) emergency shelter;

''(H) intensive case management;

''(I) diagnostic services; and

''(J) promotion of healthy approaches to risk and safety issues, including injury prevention.

''(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

''(A) preschool and school age fetal alcohol spectrum disorder services, including assessment and behavioral intervention;

''(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

''(C) identification and treatment of co-occurring disorders and comorbidity;

''(D) prevention of alcohol, drug, inhalant, and tobacco use;

''(E) early intervention, treatment, and aftercare;

''(F) promotion of healthy approaches to risk and safety issues; and

''(G) identification and treatment of neglect and physical, mental, and sexual abuse.

''(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches for risk-related behavior;

''(E) treatment services for women at risk of giving birth to a child with a fetal alcohol spectrum disorder; and

''(F) sex specific treatment for sexual assault and domestic violence.

''(4) FAMILY CARE.—Behavioral health services for families, including—

''(A) early intervention, treatment, and aftercare for affected families;

''(B) treatment for sexual assault and domestic violence; and

''(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

''(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

''(A) early intervention, treatment, and aftercare;

''(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

''(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

''(D) promotion of healthy approaches to managing conditions related to aging;

''(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

''(F) identification and treatment of dementias regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) ESTABLISHMENT.—The governing body of any Indian tribe, tribal organization, or urban Indian organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

''(2) TECHNICAL ASSISTANCE.—At the request of an Indian tribe, tribal organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization in the development and implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may make funding available to Indian tribes and tribal organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

''(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 703. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF INTERIOR.

''(a) CONTENTS.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

''(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

''(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service unit, Service area, and headquarters levels to address the problems identified in paragraph (1).

''(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian tribes and tribal organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

''(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

''(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 702(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

''(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian tribes and tribal organizations.

''(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse

among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 704. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include, if feasible and appropriate, systems of care, and shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

''(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

''(F) diagnostic services.

''(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

''SEC. 705. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, shall supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this section involves the use and promotion of the traditional health care practices of the Indian tribes to be served.

''SEC. 706. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''(a) IN GENERAL.—Subject to section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

''(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

''(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

''(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

''(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

''SEC. 707. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) GRANTS.—The Secretary, consistent with section 702, may make grants to Indian tribes, tribal organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used—

''(1) to develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol spectrum disorders;

''(2) to identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) to develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—20 percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

''SEC. 708. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 702, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an area office.

''(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

''(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

''(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian tribes to be served by such center.

''(4) SPECIFIC PROVISION OF FUNDS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

''(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

''(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(*l*) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(*l*)).

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, may provide intermediate behavioral health services, which may, if feasible and appropriate, incorporate systems of care, to Indian children and adolescents, including—

''(A) pretreatment assistance;

''(B) inpatient, outpatient, and aftercare services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) for intensive home- and community-based services.

''(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, in consultation with Indian tribes and tribal organizations, shall—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

''(B) establish guidelines for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, Indian tribes, or tribal organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, shall provide, consistent with section 702, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

''(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

''(1) the number of Indian youth who are being provided mental health services through the Service and tribal health programs;

''(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and tribal health programs;

''(3) the number of youth referred to the Service or tribal health programs for mental health services;

''(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and tribal health programs, reported separately for on- and off-reservation facilities; and

''(5) the costs of the services described in paragraph (4).

''SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

''Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 area offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 710. TRAINING AND COMMUNITY EDUCATION.

''(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian tribes and tribal organizations to develop and implement, within each Service unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.

''(b) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol spectrum disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol abuse and other behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

''SEC. 711. BEHAVIORAL HEALTH PROGRAM.

''(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 702, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

''(1) The project will address significant unmet behavioral health needs among Indians.

''(2) The project will serve a significant number of Indians.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

''(5) The project may deliver services in a manner consistent with traditional health care practices.

''(6) The project is coordinated with, and avoids duplication of, existing services.

''(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

''SEC. 712. FETAL ALCOHOL SPECTRUM DISORDERS PROGRAMS.

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 702, acting through the Service, Indian tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol spectrum disorders programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

''(2) USE OF FUNDS.—

''(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

''(i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol spectrum disorders.

''(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

''(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol spectrum disorders-affected Indians and their families or caretakers.

''(iv) To develop and implement counseling and support programs in schools for fetal alcohol spectrum disorders-affected Indian children.

''(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

''(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol spectrum disorders.

''(vii) To develop and implement, in consultation with Indian tribes and tribal organizations, and in conference with urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers.

''(viii) To develop and provide training on fetal alcohol spectrum disorders to professionals providing services to Indians, including medical and allied health practitioners, social service providers, educators, and law enforcement, court officials and corrections personnel in the juvenile and criminal justice systems.

''(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

''(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol spectrum disorders among Indians.

''(ii) Community-based support services for Indians and women pregnant with Indian children.

''(iii) Community-based housing for adult Indians with fetal alcohol spectrum disorders.

''(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) SERVICES.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol spectrum disorders in Indian communities; and

''(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol spectrum disorders.

''(c) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian tribes, tribal organizations, and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

''(d) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 713. CHILD SEXUAL ABUSE PREVENTION AND TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish, consistent with section 702, in every Service area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

''(2) other members of the household or family of the victims described in paragraph (1).

''(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

''(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

''(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

''(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and urban centers.

''(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

''SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

''(a) IN GENERAL.—The Secretary, in accordance with section 702, is authorized to establish in each Service area programs involving the prevention and treatment of—

''(1) Indian victims of domestic violence or sexual abuse; and

''(2) other members of the household or family of the victims described in paragraph (1).

''(b) USE OF FUNDS.—Funds made available to carry out this section shall be used—

''(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

''(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

''(3) to purchase rape kits; and

''(4) to develop prevention and intervention models, which may incorporate traditional health care practices.

''(c) TRAINING AND CERTIFICATION.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

''(d) COORDINATION.—

''(1) IN GENERAL.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian health programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

''(A) to improve domestic violence or sexual abuse responses;

''(B) to improve forensic examinations and collection;

''(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

''(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

''(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

''SEC. 715. BEHAVIORAL HEALTH RESEARCH.

''(a) IN GENERAL.—The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian tribes, tribal organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes, or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the multifactorial causes of Indian youth suicide, including—

''(A) protective and risk factors and scientific data that identifies those factors; and

''(B) the effects of loss of cultural identity and the development of scientific data on those effects;

''(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(3) the development of models of prevention techniques.

''(b) EMPHASIS.—The effect of the interrelationships and interdependencies referred to in subsection (a)(2) on children, and the development of prevention techniques under subsection (a)(3) applicable to children, shall be emphasized.

''Subtitle B—Indian Youth Suicide Prevention

''SEC. 721. FINDINGS AND PURPOSE.

''(a) FINDINGS.—Congress finds that—

''(1)(A) the rate of suicide of American Indians and Alaska Natives is 1.9 times higher than the national average rate; and

''(B) the rate of suicide of Indian and Alaska Native youth aged 15 through 24 is—

''(i) 3.5 times the national average rate; and

''(ii) the highest rate of any population group in the United States;

''(2) many risk behaviors and contributing factors for suicide are more prevalent in Indian country than in other areas, including—

''(A) history of previous suicide attempts;

''(B) family history of suicide;

''(C) history of depression or other mental illness;

''(D) alcohol or drug abuse;

''(E) health disparities;

''(F) stressful life events and losses;

''(G) easy access to lethal methods;

''(H) exposure to the suicidal behavior of others;

''(I) isolation; and

''(J) incarceration;

''(3) according to national data for 2005, suicide was the second-leading cause of death for Indians and Alaska Natives of both sexes aged 10 through 34;

''(4)(A) the suicide rates of Indian and Alaska Native males aged 15 through 24 are—

''(i) as compared to suicide rates of males of any other racial group, up to 4 times greater; and

''(ii) as compared to suicide rates of females of any other racial group, up to 11 times greater; and

''(B) data demonstrates that, over their lifetimes, females attempt suicide 2 to 3 times more often than males;

''(5)(A) Indian tribes, especially Indian tribes located in the Great Plains, have experienced epidemic levels of suicide, up to 10 times the national average; and

''(B) suicide clustering in Indian country affects entire tribal communities;

''(6) death rates for Indians and Alaska Natives are statistically underestimated because many areas of Indian country lack the proper resources to identify and monitor the presence of disease;

''(7)(A) the Indian Health Service experiences health professional shortages, with physician vacancy rates of approximately 17 percent, and nursing vacancy rates of approximately 18 percent, in 2007;

''(B) 90 percent of all teens who die by suicide suffer from a diagnosable mental illness at time of death;

''(C) more than ½ of teens who die by suicide have never been seen by a mental health provider; and

''(D) ⅓ of health needs in Indian country relate to mental health;

''(8) often, the lack of resources of Indian tribes and the remote nature of Indian reservations make it difficult to meet the requirements necessary to access Federal assistance, including grants;

''(9) the Substance Abuse and Mental Health Services Administration and the Service have established specific initiatives to combat youth suicide in Indian country and among Indians and Alaska Natives throughout the United States, including the National Suicide Prevention Initiative of the Service, which has worked with Service, tribal, and urban Indian health programs since 2003;

''(10) the National Strategy for Suicide Prevention was established in 2001 through a Department of Health and Human Services collaboration among—

''(A) the Substance Abuse and Mental Health Services Administration;

''(B) the Service;

''(C) the Centers for Disease Control and Prevention;

''(D) the National Institutes of Health; and

''(E) the Health Resources and Services Administration; and

''(11) the Service and other agencies of the Department of Health and Human Services use information technology and other programs to address the suicide prevention and mental health needs of Indians and Alaska Natives.

''(b) PURPOSES.—The purposes of this subtitle are—

''(1) to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth, including through—

''(A) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

''(B) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

''(C) training and related support for community leaders, family members, and health and education workers who work with Indian youth;

''(D) the development of culturally relevant educational materials on suicide; and

''(E) data collection and reporting;

''(2) to encourage Indian tribes, tribal organizations, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns; and

''(3) to enhance the provision of mental health care services to Indian youth through existing grant programs of the Substance Abuse and Mental Health Services Administration.

''SEC. 722. DEFINITIONS.

''In this subtitle:

''(1) ADMINISTRATION.—The term 'Administration' means the Substance Abuse and Mental Health Services Administration.

''(2) DEMONSTRATION PROJECT.—The term 'demonstration project' means the Indian youth telemental health demonstration project authorized under section 723(a).

''(3) TELEMENTAL HEALTH.—The term 'telemental health' means the use of electronic information and telecommunications technologies to support long-distance mental health care, patient and professional-related education, public health, and health administration.

''SEC. 723. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

''(a) AUTHORIZATION.—

''(1) IN GENERAL.—The Secretary, acting through the Service, is authorized to carry out a demonstration project to award grants for the provision of telemental health services to Indian youth who—

''(A) have expressed suicidal ideas;

''(B) have attempted suicide; or

''(C) have behavioral health conditions that increase or could increase the risk of suicide.

''(2) ELIGIBILITY FOR GRANTS.—Grants under paragraph (1) shall be awarded to Indian tribes and tribal organizations that operate 1 or more facilities—

''(A) located in an area with documented disproportionately high rates of suicide;

''(B) reporting active clinical telehealth capabilities; or

''(C) offering school-based telemental health services to Indian youth.

''(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

''(4) MAXIMUM NUMBER OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian tribes and tribal organizations that—

''(A) serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide;

''(B) enter into collaborative partnerships with Service or other tribal health programs or facilities to provide services under this demonstration project;

''(C) serve an isolated community or geographic area that has limited or no access to behavioral health services; or

''(D) operate a detention facility at which Indian youth are detained.

''(5) CONSULTATION WITH ADMINISTRATION.—In developing and carrying out the demonstration project under this subsection, the Secretary shall consult with the Administration as the Federal agency focused on mental health issues, including suicide.

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—An Indian tribe or tribal organization shall use a grant received under subsection (a) for the following purposes:

''(A) To provide telemental health services to Indian youth, including the provision of—

''(i) psychotherapy;

''(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

''(iii) alcohol and substance abuse treatment.

''(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service or tribal clinicians and health services providers working with youth being served under the demonstration project.

''(C) To assist, educate, and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under the demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among those individuals and with State and local health services providers.

''(D) To develop and distribute culturally appropriate community educational materials regarding—

''(i) suicide prevention;

''(ii) suicide education;

''(iii) suicide screening;

''(iv) suicide intervention; and

''(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

''(E) To conduct data collection and reporting relating to Indian youth suicide prevention efforts.

''(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian tribe or tribal organization may use and promote the traditional health care practices of the Indian tribes of the youth to be served.

''(c) APPLICATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), to be eligible to receive a grant under subsection (a), an Indian tribe or tribal organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the project that the Indian tribe or tribal organization will carry out using the funds provided under the grant;

''(B) a description of the manner in which the project funded under the grant would—

''(i) meet the telemental health care needs of the Indian youth population to be served by the project; or

''(ii) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

''(C) evidence of support for the project from the local community to be served by the project;

''(D) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

''(E) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the behavioral health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

''(F) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

''(2) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under paragraph (1).

''(d) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian tribes and tribal organizations receiving grants under this section to collaborate to enable comparisons regarding best practices across projects.

''(e) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

''(1) describes the number of telemental health services provided; and

''(2) includes any other information that the Secretary may require.

''(f) REPORTS TO CONGRESS.—

''(1) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 2 years after the date on which the first grant is awarded under this section, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that—

''(i) describes each project funded by a grant under this section during the preceding 2-year period, including a description of the level of success achieved by the project; and

''(ii) evaluates whether the demonstration project should be continued during the period beginning on the date of termination of funding for the demonstration project under subsection (g) and ending on the date on which the final report is submitted under paragraph (2).

''(B) CONTINUATION OF DEMONSTRATION PROJECT.—On a determination by the Secretary under clause (ii) of subparagraph (A) that the demonstration project should be continued, the Secretary may carry out the demonstration project during the period described in that clause using such sums otherwise made available to the Secretary as the Secretary determines to be appropriate.

''(2) FINAL REPORT.—Not later than 270 days after the date of termination of funding for the demonstration project under subsection (g), the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a final report that—

''(A) describes the results of the projects funded by grants awarded under this section, including any data available that indicate the number of attempted suicides;

''(B) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

''(C) evaluates whether the demonstration project should be—

''(i) expanded to provide more than 5 grants; and

''(ii) designated as a permanent program; and

''(D) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2010 through 2013.

''SEC. 724. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION GRANTS.

''(a) GRANT APPLICATIONS.—

''(1) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary, acting through the Administration, shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under any program administered by the Administration, including by providing methods other than electronic methods of submitting applications for those grants, if necessary.

''(2) PRIORITY FOR CERTAIN GRANTS.—

''(A) IN GENERAL.—To fulfill the trust responsibility of the United States to Indian tribes, in awarding relevant grants pursuant to a program described in subparagraph (B), the Secretary shall take into consideration the needs of Indian tribes or tribal organizations, as applicable, that serve populations with documented high suicide rates, regardless of whether those Indian tribes or tribal organizations possess adequate personnel or infrastructure to fulfill all applicable requirements of the relevant program.

''(B) DESCRIPTION OF GRANT PROGRAMS.—A grant program referred to in subparagraph (A) is a grant program—

''(i) administered by the Administration to fund activities relating to mental health, suicide prevention, or suicide-related risk factors; and

''(ii) under which an Indian tribe or tribal organization is an eligible recipient.

''(3) CLARIFICATION REGARDING INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Notwithstanding any other provision of law, in applying for a grant under any program administered by the Administration, no Indian tribe or tribal organization shall be required to apply through a State or State agency.

''(4) REQUIREMENTS FOR AFFECTED STATES.—

''(A) DEFINITIONS.—In this paragraph:

''(i) AFFECTED STATE.—The term 'affected State' means a State—

''(I) the boundaries of which include 1 or more Indian tribes; and

''(II) the application for a grant under any program administered by the Administration of which includes statewide data.

''(ii) INDIAN POPULATION.—The term 'Indian population' means the total number of residents of an affected State who are Indian.

''(B) REQUIREMENTS.—As a condition of receipt of a grant under any program administered by the Administration, each affected State shall—

''(i) describe in the grant application—

''(I) the Indian population of the affected State; and

''(II) the contribution of that Indian population to the statewide data used by the affected State in the application; and

''(ii) demonstrate to the satisfaction of the Secretary that—

''(I) of the total amount of the grant, the affected State will allocate for use for the Indian population of the affected State an amount equal to the proportion that—

''(aa) the Indian population of the affected State; bears to

''(bb) the total population of the affected State; and

''(II) the affected State will take reasonable efforts to collaborate with each Indian tribe located within the affected State to carry out youth suicide prevention and treatment measures for members of the Indian tribe.

''(C) REPORT.—Not later than 1 year after the date of receipt of a grant described in subparagraph (B), an affected State shall submit to the Secretary a report describing the measures carried out by the affected State to ensure compliance with the requirements of subparagraph (B)(ii).

''(b) NO NON-FEDERAL SHARE REQUIREMENT.—Notwithstanding any other provision of law, no Indian tribe or tribal organization shall be required to provide a non-Federal share of the cost of any project or activity carried out using a grant provided under any program administered by the Administration.

''(c) OUTREACH FOR RURAL AND ISOLATED INDIAN TRIBES.—Due to the rural, isolated nature of most Indian reservations and communities (especially those reservations and communities in the Great Plains region), the Secretary shall conduct outreach activities, with a particular emphasis on the provision of telemental health services, to achieve the purposes of this subtitle with respect to Indian tribes located in rural, isolated areas.

''(d) PROVISION OF OTHER ASSISTANCE.—

''(1) IN GENERAL.—The Secretary, acting through the Administration, shall carry out such measures (including monitoring and the provision of required assistance) as the Secretary determines to be necessary to ensure the provision of adequate suicide prevention and mental health services to Indian tribes described in paragraph (2), regardless of whether those Indian tribes possess adequate personnel or infrastructure—

''(A) to submit an application for a grant under any program administered by the Administration, including due to problems relating to access to the Internet or other electronic means that may have resulted in previous obstacles to submission of a grant application; or

''(B) to fulfill all applicable requirements of the relevant program.

''(2) DESCRIPTION OF INDIAN TRIBES.—An Indian tribe referred to in paragraph (1) is an Indian tribe—

''(A) the members of which experience—

''(i) a high rate of youth suicide;

''(ii) low socioeconomic status; and

''(iii) extreme health disparity;

''(B) that is located in a remote and isolated area; and

''(C) that lacks technology and communication infrastructure.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as the Secretary determines to be necessary to carry out this subsection.

''(e) EARLY INTERVENTION AND ASSESSMENT SERVICES.—

''(1) DEFINITION OF AFFECTED ENTITY.—In this subsection, the term 'affected entity' means any entity—

''(A) that receives a grant for suicide intervention, prevention, or treatment under a program administered by the Administration; and

''(B) the population to be served by which includes Indian youth.

''(2) REQUIREMENT.—The Secretary, acting through the Administration, shall ensure that each affected entity carrying out a youth suicide early intervention and prevention strategy described in section 520E(c)(1) of the Public Health Service Act (42 U.S.C. 290bb–36(c)(1)), or any other youth suicide-related early intervention and assessment activity, provides training or education to individuals who interact frequently with the Indian youth to be served by the affected entity (including parents, teachers, coaches, and mentors) on identifying warning signs of Indian youth who are at risk of committing suicide.

''SEC. 725. USE OF PREDOCTORAL PSYCHOLOGY AND PSYCHIATRY INTERNS.

''The Secretary shall carry out such activities as the Secretary determines to be necessary to encourage Indian tribes, tribal organizations, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns—

''(1) to increase the quantity of patients served by the Indian tribes, tribal organizations, and other mental health care providers; and

''(2) for purposes of recruitment and retention.

''SEC. 726. INDIAN YOUTH LIFE SKILLS DEVELOPMENT DEMONSTRATION PROGRAM.

''(a) PURPOSE.—The purpose of this section is to authorize the Secretary, acting through

the Administration, to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide, including through—

''(1) the establishment of tribal partnerships to develop and implement such a curriculum, in cooperation with—

''(A) behavioral health professionals, with a priority for tribal partnerships cooperating with mental health professionals employed by the Service;

''(B) tribal or local school agencies; and

''(C) parent and community groups;

''(2) the provision by the Administration or the Service of—

''(A) technical expertise; and

''(B) clinicians, analysts, and educators, as appropriate;

''(3) training for teachers, school administrators, and community members to implement the curriculum;

''(4) the establishment of advisory councils composed of parents, educators, community members, trained peers, and others to provide advice regarding the curriculum and other components of the demonstration program;

''(5) the development of culturally appropriate support measures to supplement the effectiveness of the curriculum; and

''(6) projects modeled after evidence-based projects, such as programs evaluated and published in relevant literature.

''(b) DEMONSTRATION GRANT PROGRAM.—

''(1) DEFINITIONS.—In this subsection:

''(A) CURRICULUM.—The term 'curriculum' means the culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide identified by the Secretary under paragraph (2)(A).

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(i) an Indian tribe;

''(ii) a tribal organization;

''(iii) any other tribally authorized entity; and

''(iv) any partnership composed of 2 or more entities described in clause (i), (ii), or (iii).

''(2) ESTABLISHMENT.—The Secretary, acting through the Administration, may establish and carry out a demonstration program under which the Secretary shall—

''(A) identify a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide;

''(B) identify the Indian tribes that are at greatest risk for adolescent suicide;

''(C) invite those Indian tribes to participate in the demonstration program by—

''(i) responding to a comprehensive program requirement request of the Secretary; or

''(ii) submitting, through an eligible entity, an application in accordance with paragraph (4); and

''(D) provide grants to the Indian tribes identified under subparagraph (B) and eligible entities to implement the curriculum with respect to Indian and Alaska Native youths who—

''(i) are between the ages of 10 and 19; and

''(ii) attend school in a region that is at risk of high youth suicide rates, as determined by the Administration.

''(3) REQUIREMENTS.—

''(A) TERM.—The term of a grant provided under the demonstration program under this section shall be not less than 4 years.

''(B) MAXIMUM NUMBER.—The Secretary may provide not more than 5 grants under the demonstration program under this section.

''(C) AMOUNT.—The grants provided under this section shall be of equal amounts.

''(D) CERTAIN SCHOOLS.—In selecting eligible entities to receive grants under this section, the Secretary shall ensure that not less than 1 demonstration program shall be carried out at each of—

''(i) a school operated by the Bureau of Indian Education;

''(ii) a Tribal school; and

''(iii) a school receiving payments under section 8002 or 8003 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7702, 7703).

''(4) APPLICATIONS.—To be eligible to receive a grant under the demonstration program, an eligible entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) an assurance that, in implementing the curriculum, the eligible entity will collaborate with 1 or more local educational agencies, including elementary schools, middle schools, and high schools;

''(B) an assurance that the eligible entity will collaborate, for the purpose of curriculum development, implementation, and training and technical assistance, with 1 or more—

''(i) nonprofit entities with demonstrated expertise regarding the development of culturally sensitive, school-based, youth suicide prevention and intervention programs; or

''(ii) institutions of higher education with demonstrated interest and knowledge regarding culturally sensitive, school-based, life skills youth suicide prevention and intervention programs;

''(C) an assurance that the curriculum will be carried out in an academic setting in conjunction with at least 1 classroom teacher not less frequently than twice each school week for the duration of the academic year;

''(D) a description of the methods by which curriculum participants will be—

''(i) screened for mental health at-risk indicators; and

''(ii) if needed and on a case-by-case basis, referred to a mental health clinician for further assessment and treatment and with crisis response capability; and

''(E) an assurance that supportive services will be provided to curriculum participants identified as high-risk participants, including referral, counseling, and follow-up services for—

''(i) drug or alcohol abuse;

''(ii) sexual or domestic abuse; and

''(iii) depression and other relevant mental health concerns.

''(5) USE OF FUNDS.—An Indian tribe identified under paragraph (2)(B) or an eligible entity may use a grant provided under this subsection—

''(A) to develop and implement the curriculum in a school-based setting;

''(B) to establish an advisory council—

''(i) to advise the Indian tribe or eligible entity regarding curriculum development; and

''(ii) to provide support services identified as necessary by the community being served by the Indian tribe or eligible entity;

''(C) to appoint and train a school- and community-based cultural resource liaison, who will act as an intermediary among the Indian tribe or eligible entity, the applicable school administrators, and the advisory council established by the Indian tribe or eligible entity;

''(D) to establish an on-site, school-based, MA- or PhD-level mental health practitioner (employed by the Service, if practicable) to work with tribal educators and other personnel;

''(E) to provide for the training of peer counselors to assist in carrying out the curriculum;

''(F) to procure technical and training support from nonprofit or State entities or institutions of higher education identified by the community being served by the Indian tribe or eligible entity as the best suited to develop and implement the curriculum;

''(G) to train teachers and school administrators to effectively carry out the curriculum;

''(H) to establish an effective referral procedure and network;

''(I) to identify and develop culturally compatible curriculum support measures;

''(J) to obtain educational materials and other resources from the Administration or other appropriate entities to ensure the success of the demonstration program; and

''(K) to evaluate the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide.

''(c) EVALUATIONS.—Using such amounts made available pursuant to subsection (e) as the Secretary determines to be appropriate, the Secretary shall conduct, directly or through a grant, contract, or cooperative agreement with an entity that has experience regarding the development and operation of successful culturally compatible, school-based, life skills suicide prevention and intervention programs or evaluations, an annual evaluation of the demonstration program under this section, including an evaluation of—

''(1) the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

''(2) areas for program improvement; and

''(3) additional development of the goals and objectives of the demonstration program.

''(d) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Subject to paragraph (2), not later than 180 days after the date of termination of the demonstration program, the Secretary shall submit to the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Natural Resources and the Committee on Education and Labor of the House of Representatives a final report that—

''(A) describes the results of the program of each Indian tribe or eligible entity under this section;

''(B) evaluates the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

''(C) makes recommendations regarding—

''(i) the expansion of the demonstration program under this section to additional eligible entities;

''(ii) designating the demonstration program as a permanent program; and

''(iii) identifying and distributing the curriculum through the Suicide Prevention Resource Center of the Administration; and

''(D) incorporates any public comments received under paragraph (2).

''(2) PUBLIC COMMENT.—The Secretary shall provide a notice of the report under paragraph (1) and an opportunity for public comment on the report for a period of not less than 90 days before submitting the report to Congress.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2010 through 2014.''.

Subtitle H—Miscellaneous

SEC. 191. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

Title VIII of the Indian Health Care Improvement Act (as amended by section

101(b)) is amended by inserting after section 804 (25 U.S.C. 1674) the following:

"SEC. 805. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

''(a) DEFINITIONS.—In this section:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 119, who is—

''(A) granted clinical practice privileges or employed to provide health care services at—

''(i) an Indian health program; or

''(ii) a health program of an urban Indian organization; and

''(B) licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

''(2) MEDICAL QUALITY ASSURANCE PROGRAM.—The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 by or for any Indian health program or urban Indian organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian health program or urban Indian organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review, and identification and prevention of medical or dental incidents and risks.

''(3) MEDICAL QUALITY ASSURANCE RECORD.—The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that—

''(A) emanate from quality assurance program activities described in paragraph (2); and

''(B) are produced or compiled by or for an Indian health program or urban Indian organization as part of a medical quality assurance program.

''(b) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian health program or a health program of an urban Indian organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (d).

''(c) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (b) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (d).

''(2) TESTIMONY.—An individual who reviews or creates medical quality assurance records for any Indian health program or urban Indian organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

''(d) AUTHORIZED DISCLOSURE AND TESTIMONY.—

''(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (b) may be disclosed, and an individual referred to in subsection (c) may give testimony in connection with such a record, only as follows:

''(A) To a Federal agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian health program or to a health program of an urban Indian organization to perform monitoring, required by law, of such program or organization.

''(B) To an administrative or judicial proceeding commenced by a present or former Indian health program or urban Indian organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

''(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization.

''(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian health program or urban Indian organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

''(E) To an officer, employee, or contractor of the Indian health program or urban Indian organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

''(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

''(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

''(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian health program or urban Indian organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (b) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization.

''(e) DISCLOSURE FOR CERTAIN PURPOSES.—

''(1) IN GENERAL.—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian health program or urban Indian organization's medical quality assurance programs.

''(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

''(f) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—An individual or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

''(g) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (b) may not be made available to any person under section 552 of title 5, United States Code.

''(h) LIMITATION ON CIVIL LIABILITY.—An individual who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (b) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

''(i) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

''(j) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

''(k) CONTINUED PROTECTION.—Disclosure under subsection (d) does not permit redisclosure except to the extent such further disclosure is authorized under subsection (d) or is otherwise authorized to be disclosed under this section.

''(l) INCONSISTENCIES.—To the extent that the protections under part C of title IX of the Public Health Service Act (42 U.S.C. 229b–21 et seq.) (as amended by the Patient Safety and Quality Improvement Act of 2005 (Public Law 109–41; 119 Stat. 424)) and this section are inconsistent, the provisions of whichever is more protective shall control.

''(m) RELATIONSHIP TO OTHER LAW.—This section shall continue in force and effect, except as otherwise specifically provided in any Federal law enacted after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009.''.

SEC. 192. ARIZONA, NORTH DAKOTA, AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREAS; ELIGIBILITY OF CALIFORNIA INDIANS.

Title VIII of the Indian Health Care Improvement Act is amended—

(1) by striking section 808 (25 U.S.C. 1678) and inserting the following:

"SEC. 808. ARIZONA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—The State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the State of Arizona.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if the curtailment is due to the provision of contract services in that State pursuant to the designation of the State as a contract health service delivery area by subsection (a).'';

(2) by inserting after section 808 (25 U.S.C. 1678) the following:

"SEC. 808A. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—The States of North Dakota and South Dakota shall be designated

as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

''(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those States pursuant to the designation of the States as a contract health service delivery area by subsection (a).''; and

(3) by striking section 809 (25 U.S.C. 1679) and inserting the following:

''SEC. 809. ELIGIBILITY OF CALIFORNIA INDIANS.

''(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

''(1) Any member of a federally recognized Indian tribe.

''(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

''(A) is a member of the Indian community served by a local program of the Service; and

''(B) is regarded as an Indian by the community in which such descendant lives.

''(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

''(4) Any Indian of California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.''.

SEC. 193. METHODS TO INCREASE ACCESS TO PROFESSIONALS OF CERTAIN CORPS.

Section 812 of the Indian Health Care Improvement Act (25 U.S.C. 1680b) is amended to read as follows:

''SEC. 812. NATIONAL HEALTH SERVICE CORPS.

''(a) NO REDUCTION IN SERVICES.—The Secretary shall not remove a member of the National Health Service Corps from an Indian health program or urban Indian organization or withdraw funding used to support such a member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from the member will experience no reduction in services.

''(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—At the request of an Indian health program, the services of a member of the National Health Service Corps assigned to the Indian health program may be limited to the individuals who are eligible for services from that Indian health program.''.

SEC. 194. HEALTH SERVICES FOR INELIGIBLE PERSONS.

Section 813 of the Indian Health Care Improvement Act (25 U.S.C. 1680c) is amended to read as follows:

''SEC. 813. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) HEALTH FACILITIES PROVIDING HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the Service unit and who are not otherwise eligible for such health services if—

''(A) the Indian tribes served by such Service unit requests such provision of health services to such individuals, and

''(B) the Secretary and the served Indian tribes have jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians.

''(2) ISDEAA PROGRAMS.—In the case of health facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the consideration described in paragraph (1)(B). Any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act. The provisions of section 314 of Public Law 101–512 (104 Stat. 1959), as amended by section 308 of Public Law 103–138 (107 Stat. 1416), shall apply to any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph.

''(3) PAYMENT FOR SERVICES.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 207 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or children's health insurance program reimbursements under titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395 et seq.), shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

''(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

''(4) REVOCATION OF CONSENT FOR SERVICES.—

''(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

''(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the Service Area revoke their concurrence to the provisions of such health services.

''(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

''(4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

''(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

''(1) IN GENERAL.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

''(2) DEFINITION.—For purposes of this subsection, the term 'non-Service health care practitioner' means a practitioner who is not—

''(A) an employee of the Service; or

''(B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an individual who provides health care services pursuant to a personal services contract with such Indian tribe or tribal organization.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.''.

SEC. 195. ANNUAL BUDGET SUBMISSION.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding at the end the following:

''SEC. 826. ANNUAL BUDGET SUBMISSION.

''Effective beginning with the submission of the annual budget request to Congress for fiscal year 2011, the President shall include, in the amount requested and the budget justification, amounts that reflect any changes in—

''(1) the cost of health care services, as indexed for United States dollar inflation (as measured by the Consumer Price Index); and

''(2) the size of the population served by the Service.''.

SEC. 196. PRESCRIPTION DRUG MONITORING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 195) is amended by adding at the end the following:

''SEC. 827. PRESCRIPTION DRUG MONITORING.

''(a) MONITORING.—

''(1) ESTABLISHMENT.—The Secretary, in coordination with the Secretary of the Interior and the Attorney General, shall establish a prescription drug monitoring program, to be carried out at health care facilities of the Service, tribal health care facilities, and urban Indian health care facilities.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

''(A) the needs of the Service, tribal health care facilities, and urban Indian health care facilities with respect to the prescription drug monitoring program under paragraph (1);

''(B) the planned development of that program, including any relevant statutory or administrative limitations; and

''(C) the means by which the program could be carried out in coordination with any State prescription drug monitoring program.

''(b) ABUSE.—

''(1) IN GENERAL.—The Attorney General, in conjunction with the Secretary and the Secretary of the Interior, shall conduct—

''(A) an assessment of the capacity of, and support required by, relevant Federal and tribal agencies—

''(i) to carry out data collection and analysis regarding incidents of prescription drug abuse in Indian communities; and

''(ii) to exchange among those agencies and Indian health programs information relating to prescription drug abuse in Indian communities, including statutory and administrative requirements and limitations relating to that abuse; and

''(B) training for Indian health care providers, tribal leaders, law enforcement officers, and school officials regarding awareness and prevention of prescription drug abuse and strategies for improving agency responses to addressing prescription drug abuse in Indian communities.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Attorney General shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

''(A) the capacity of Federal and tribal agencies to carry out data collection and analysis and information exchanges as described in paragraph (1)(A);

''(B) the training conducted pursuant to paragraph (1)(B);

''(C) infrastructure enhancements required to carry out the activities described in paragraph (1), if any; and

''(D) any statutory or administrative barriers to carrying out those activities.''.

SEC. 197. TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 196) is amended by adding at the end the following:

''SEC. 828. TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

''(a) IN GENERAL.—Nothing in this Act limits the ability of a tribal health program operating any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a compact with the Service pursuant to title V of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 458aaa et seq.) to charge an Indian for services provided by the tribal health program.

''(b) SERVICE.—Nothing in this Act authorizes the Service—

''(1) to charge an Indian for services; or

''(2) to require any tribal health program to charge an Indian for services.''.

SEC. 198. DISEASE AND INJURY PREVENTION REPORT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 197) is amended by adding at the end the following:

''SEC. 829. DISEASE AND INJURY PREVENTION REPORT.

''Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committees on Natural Resources and Energy and Commerce of the House of Representatives describing—

''(1) all disease and injury prevention activities conducted by the Service, independently or in conjunction with other Federal departments and agencies and Indian tribes; and

''(2) the effectiveness of those activities, including the reductions of injury or disease conditions achieved by the activities.''.

SEC. 199. OTHER GAO REPORTS.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 198) is amended by adding at the end the following:

''SEC. 830. OTHER GAO REPORTS.

''(a) COORDINATION OF SERVICES.—

''(1) STUDY AND EVALUATION.—The Comptroller General of the United States shall conduct a study, and evaluate the effectiveness, of coordination of health care services provided to Indians—

''(A) through Medicare, Medicaid, or SCHIP;

''(B) by the Service; or

''(C) using funds provided by—

''(i) State or local governments; or

''(ii) Indian tribes.

''(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report—

''(A) describing the results of the evaluation under paragraph (1); and

''(B) containing recommendations of the Comptroller General regarding measures to support and increase coordination of the provision of health care services to Indians as described in paragraph (1).

''(b) PAYMENTS FOR CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Comptroller General shall conduct a study on the use of health care furnished by health care providers under the contract health services program funded by the Service and operated by the Service, an Indian tribe, or a tribal organization.

''(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

''(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for that health care through other public programs and in the private sector;

''(B) barriers to accessing care under such contract health services program, including barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under the program;

''(C) the adequacy of existing Federal funding for health care under the contract health services program;

''(D) the administration of the contract health service program, including the distribution of funds to Indian health programs pursuant to the program; and

''(E) any other items determined appropriate by the Comptroller General.

''(3) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations regarding—

''(A) the appropriate level of Federal funding that should be established for health care under the contract health services program described in paragraph (1);

''(B) how to most efficiently use that funding; and

''(C) the identification of any inequities in the current distribution formula or inequitable results for any Indian tribe under the funding level, and any recommendations for addressing any inequities or inequitable results identified.

''(4) CONSULTATION.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Comptroller General shall consult with the Service, Indian tribes, and tribal organizations.''.

SEC. 199A. TRADITIONAL HEALTH CARE PRACTICES.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 199) is amended by adding at the end the following:

''SEC. 831. TRADITIONAL HEALTH CARE PRACTICES.

''Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this Act, the United States is not liable for any provision of traditional health care practices pursuant to this Act that results in damage, injury, or death to a patient. Nothing in this subsection shall be construed to alter any liability or other obligation that the United States may otherwise have under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or this Act.''.

SEC. 199B. DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) (as amended by section 199A) is amended by adding at the end the following:

''SEC. 832. DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish within the Service the position of the Director of

HIV/AIDS Prevention and Treatment (referred to in this section as the 'Director').

''(b) DUTIES.—The Director shall—

''(1) coordinate and promote HIV/AIDS prevention and treatment activities specific to Indians;

''(2) provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations regarding existing HIV/AIDS prevention and treatment programs; and

''(3) ensure interagency coordination to facilitate the inclusion of Indians in Federal HIV/AIDS research and grant opportunities, with emphasis on the programs operated under the Ryan White Comprehensive Aids Resources Emergency Act of 1990 (Public Law 101–381; 104 Stat. 576) and the amendments made by that Act.

''(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, and not less frequently than once every 2 years thereafter, the Director shall submit to Congress a report describing, with respect to the preceding 2-year period—

''(1) each activity carried out under this section; and

''(2) any findings of the Director with respect to HIV/AIDS prevention and treatment activities specific to Indians.''.

TITLE II—AMENDMENTS TO OTHER ACTS

SEC. 201. MEDICARE AMENDMENTS.

(a) IN GENERAL.—Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following:

''(f) PROHIBITION.—Payments made pursuant to this section shall not be reduced as a result of any beneficiary deductible, coinsurance, or other charge under section 1813.''.

(b) PAYMENT OF BENEFITS.—Section 1833(a)(1)(B) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(B)) is amended by inserting ''or 1880(e)'' after ''section 1861(s)(10)(A)''.

SEC. 202. REAUTHORIZATION OF NATIVE HAWAIIAN HEALTH CARE PROGRAMS.

(a) REAUTHORIZATION.—The Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11701 et seq.) is amended by striking ''2001'' each place it appears in sections 6(h)(1), 7(b), and 10(c) (42 U.S.C. 11705(h)(1), 11706(b), 11709(c)) and inserting ''2019''.

(b) HEALTH AND EDUCATION.—

(1) IN GENERAL.—Section 6(c) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11705) is amended by adding at the end the following:

''(4) HEALTH AND EDUCATION.—In order to enable privately funded organizations to continue to supplement public efforts to provide educational programs designed to improve the health, capability, and well-being of Native Hawaiians and to continue to provide health services to Native Hawaiians, notwithstanding any other provision of Federal or State law, it shall be lawful for the private educational organization identified in section 7202(16) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7512(16)) to continue to offer its educational programs and services to Native Hawaiians (as defined in section 7207 of that Act (20 U.S.C. 7517)) first and to others only after the need for such programs and services by Native Hawaiians has been met.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on December 5, 2006.

(c) DEFINITION OF HEALTH PROMOTION.—Section 12(2) of the Native Hawaiian Health Care Act of 1988 (42 U.S.C. 11711(2)) is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) in subparagraph (G), by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following:

''(H) educational programs with the mission of improving the health, capability, and well-being of Native Hawaiians.''.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Sarah Allen, Ryan Nalty, and Grant Jamieson, staff of the Finance Committee, be granted the privilege of the floor for the duration of debate on the health care bill.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Sara Velde of Senator HARKIN's staff be granted the privilege of the floor during the duration of today's session.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

DISCHARGE AND REFERRAL—S. 2129

Mr. BAUCUS. I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be discharged from further consideration of S. 2129 and the bill be referred to the Committee on Environment and Public Works.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUPPORTING PEACE, SECURITY, AND INNOCENT CIVILIANS AFFECTED BY CONFLICT IN YEMEN

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 212, S. Res. 341.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 341) supporting peace, security, and innocent civilians affected by conflict in Yemen.

There being no objection, the Senate proceeded to consider the resolution.

Mr. BAUCUS. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements relating to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 341) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 341

Whereas the people and Government of Yemen currently face tremendous security challenges, including the presence of a substantial number of al Qaeda militants, a rebellion in the northern part of the country, unrest in southern regions, and piracy in the Gulf of Aden;

Whereas these security challenges are compounded by a lack of governance throughout portions of the country;

Whereas this lack of governance creates a de facto safe haven for al Qaeda and militant forces in regions of Yemen;

Whereas Yemen also faces significant development challenges, reflected in its ranking of 140 out of 182 countries in the United Nations Development Program's 2009 Human Development Index;

Whereas Yemen is also confronted with limited and rapidly depleting natural resources, including oil, which accounts for over 75 percent of government revenue, and water, ⅓ of which goes to the cultivation of qat, a narcotic to which a vast number of Yemenis are addicted;

Whereas government subsidies are contributing to the depletion of Yemen's scarce resources;

Whereas the people of Yemen suffer from a lack of certain government services, including a robust education and skills training system;

Whereas the Department of State's 2009 International Religious Freedom Report notes that nearly all of the once-sizeable Jewish population in Yemen has emigrated, and, based on fears for the Jewish community's safety in the country, the United States Government has initiated a special process to refer Yemeni Jews for refugee resettlement in the United States;

Whereas women in Yemen have faced entrenched discrimination, obstacles in accessing basic education, and gender-based violence in their homes, communities, and workplaces while little is done to enforce or bolster the equality of women;

Whereas these challenges pose a threat not only to the Republic of Yemen, but to the region and to the national security of the United States;

Whereas, to the extent that Yemen serves as a base for terrorist operations and recruitment, these threats must be given sufficient consideration in the global strategy of the United States to combat terrorism;

Whereas this threat has materialized in the past, including the March 18 and September 17, 2008, attacks on the United States Embassy in Sana'a and the October 12, 2000, attack on the U.S.S. Cole while it was anchored in the Port of Aden, as well as numerous other terrorist attacks;

Whereas the population of Yemen has suffered greatly from conflict and underdevelopment in Yemen;

Whereas up to 150,000 civilians have fled their homes in northern Yemen since 2004 in response to conflict between Government of Yemen forces and al-Houthi rebel forces; and

Whereas the people and Government of the United States support peace in Yemen and improved security, economic development, and basic human rights for the people of Yemen: Now, therefore, be it

Resolved, That the Senate—

(1) supports the innocent civilians in Yemen, especially displaced persons, who have suffered from instability, terrorist operations, and chronic underdevelopment in Yemen;

(2) recognizes the serious threat instability and terrorism in Yemen pose to the security of the United States, the region, and the population in Yemen;

(3) calls on the President to give sufficient weight to the situation in Yemen in efforts to prevent terrorist attacks on the United States, United States allies, and Yemeni civilians;

(4) calls on the President to promote economic and political reforms necessary to advance economic development and good governance in Yemen;